TOWARDS A BLUEPRINT FOR CHANGE: A MENTAL HEALTH POLICY AND PROGRAM PERSPECTIVE

DISCUSSION PAPER

BY

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The Honourable Keith C. Norton, Q.C.
Minister of Health
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Dear Mr. Minister:

I take pleasure in submitting herewith my final discussion paper entitled **Towards a Blueprint for Change: A Mental Health Policy and Program Perspective.** The paper contains a review and assessment of mental health services in Ontario, and recommended policy directions for the development of these services over the next ten years.

A paper of this kind, by its very nature, tends to focus on what needs to be rectified or altered rather than on the positive aspects of current services. I want to acknowledge at the outset, therefore, that the people of Ontario enjoy a level of health care service that is equalled in only a few other jurisdictions and surpassed in none. In the mental health field, however, there appear to be more gaps and more need for strengthening existing services than in the other sectors of health care. This is understandable, perhaps, in light of the bias, misinformation, emotionalism and definitional problems associated with mental illness.

The multiplicity of resources required to provide an adequate continuum of services for individuals, particularly those suffering from serious mental illness with a high level of chronicity, presents a formidable task of planning and co-ordination amongst different levels of government, provincial ministries, agencies, professionals and volunteers. I have attempted to set out a description of the current situation and to identify those areas where there are gaps and where existing services require strengthening and improved co-ordination and integration.

It is my hope that this Discussion Paper will be useful to your Ministry in developing and implementing policies and programs which will provide a balanced mental health care system for the people of Ontario.

Yours sincerely,

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1.0 INTRODUCTION

This Discussion Paper is the result of a two year review and assessment of mental health services in Ontario. Consideration was given to all aspects of mental health services including the organization, delivery and program content of services and the resources available to provide those services.

The recommendations build upon the Ministry's policy of deinstitutionalization and its increasing emphasis upon decentralized non-institutional services. The paper also emphasizes the need to set priorities, to make better use of available resources and to fill gaps in services.

There is no universally accepted definition of mental illness. This Discussion Paper employs a functional approach which assumes that mental health services are required when a person's mental state is such that it diminishes his or her ability to cope to such an extent that family and friends are unable to help. This covers a range of mental illness from transitory emotional crises to profound, prolonged and disabling psychoses.

It is likely that eight per cent or more of the Ontario residents in any one year receive medical services for a psychiatric diagnosis, and a similar proportion receive non-psychiatric mental health services. The demand for mental health services is increasing: the "baby boom" population is now entering the 25 to 45 year category, the age category which typically makes the heaviest use of psychiatric facilities; as well, the general population is aging, a trend which has important consequences for psychogeriatric services.

In the current economic situation it is unrealistic to expect a major infusion of additional funds for mental health care. Therefore, in order to meet the current and future demand for services, priorities need to be established so that: (1) essential services are in place; (2) the most needy receive the services they require; and (3) mental health resources are used to their maximum benefit.

A primary goal of this paper is to support the trend towards the development of a continuum of treatment modes ranging from specialized psychiatric intervention to lay counselling, in a continuum of settings ranging from psychiatric institutions to home care, so that the mentally ill person can receive the treatment and/or support most appropriate to his or her needs in the most suitable setting as close to home as is practical.

The Ministry of Health has only a limited ability, acting on its own, to accomplish changes in mental health services. Aside from the provincial psychiatric hospitals, the Ministry does not provide services directly, but funds hospitals, community agencies, associations and individual physicians to do so. In addition, the Ministry of Health's responsibility is primarily for adult mental health services, with services for children and adolescents primarily the responsibility of the Ministry of Community and Social Services. Other Ministries and levels of government also have responsibilities which have a major impact upon the mental health field. Consequently, the Ministry of Health must rely upon inter-agency and interministry co-ordinating mechanisms for planning and service delivery. Recommendations in the Discussion Paper deal with ways to strengthen these mechanisms.

The major issues and recommendations are dealt with under three major categories: planning and co-ordination, continuity of care and human resources. More specialized matters are discussed separately.(1) Because of the Ministry of Health's on-going initiatives in the mental health field, some recommendations may refer to activities already underway.

2.0 PLANNING AND CO-ORDINATION

The recommendations have two thrusts: (1) to define a suitable distribution of essential services among the five levels of planning and co-ordination - individual case, local, district, regional and provincial; and (2) to develop mechanisms to facilitate planning and co-ordination at each level and between levels.

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(1) Only the more central recommendations are summarized. For all the recommendations and their rationale, the reader should turn to Section IV of the Discussion Paper.

2.1 DISTRIBUTION OF ESSENTIAL MENTAL HEALTH SERVICES

Following is the recommended distribution of essential mental health services at the local, district, regional and provincial levels. When these essential services are provided, the basic elements of a balanced mental health service system will be largely in place. The number of such essential services at each level, their geographical distribution and their organization are matters to be decided by the responsible planning and co-ordinating body at that level.

At the health district level, essential services include: (1) the services required of Schedule 1 psychiatric facilities; (2) specialized assessment, diagnosis and short-term treatment services for psychogeriatrics, addictions, and the disturbed mentally retarded (may be provided at the regional level in less populated areas); (3) rehabilitation and maintenance services; and (4) prevention programs. All of these essential services are delivered in local communities. In addition, another essential service at the local level is case management.

Essential services at the regional level include: (1) medium secure forensic; and (2) inpatient chronic care services. At the provincial level, essential services include: (1) maximum secure forensic; (2) long-term maximum secure treatment for seriously disturbed children and adolescents; and (3) other specialized services as required.

2.2 LEVELS OF PLANNING AND CO-ORDINATION

Planning and co-ordination mechanisms are required at six levels - individual case, local, district, region, Ministry of Health and interministry.

Individual Case

Case managers are the primary co-ordinators of services for the individual mentally ill person, ensuring that the person has access to all the required services. More case management services are required, with first priority given to those chronically mentally ill persons with reduced ability to cope already living in the community, about 0.35 to 1.0 per cent of the population, and to psychiatric hospital patients about to be discharged into the community. It is also recommended that case management services be sponsored by an agency linked to a psychiatric facility for assessment and consultation.

Local

There is no formally designated planning and co-ordination body at the local level. This function is the responsibility of the District Health Councils. To facilitate co-ordination at the local level, local agencies, in their program submissions for review by the District Health Council, need to detail how the proposed program will be co-ordinated with existing local services and to demonstrate the agreement of the affected local services. All programs should be evaluated at least once a year.

District

A District Health Council or equivalent, with a mental health committee responsible for district planning and co-ordination , is required in each health district. The Councils need Ministry guidelines for the preparation of their mental health plans, and these plans should be consistent with both provincial and district priorities. It is also recommended that the Councils formally review their mental health plans and priorities annually, and that representation on the mental health committees be broadened.

Region

To provide a forum for establishing regional objectives and priorities and co-ordinating the work of the District Health Councils within the region, it is recommended that a Regional Mental Health Committee be established in each health planning region.

Ministry of Health

Co-ordinating mechanisms within the Ministry of Health need to be strengthened to deal with three aspects of internal planning and co-ordination: (1) divided responsibility for psychiatric hospital beds and services between the Mental Health and Institutional Divisions; (2) divided responsibility for the "mental health budget"; and (3) the statutory foundations. Possibilities include a strengthened Area Health Services Committee or a co-ordinating committee at the Assistant Deputy Minister level. Memoranda of Understanding should be established with the statutory foundations.

Interministry

Interministry committees already exist to deal with some service areas where there is divided responsibility among ministries. As new interministry committees are required, it is necessary that they be established at the Assistant Deputy Minister level to give them the authority to implement decisions.

3.0 CONTINUITY OF CARE

Three dimensions of continuity of care require immediate attention: (1) psychiatric crisis services for children and adults; (2) child and adolescent mental health services; and (3) rehabilitation and maintenance services for the psychiatrically disabled.

3.1 CRISIS SERVICES

Psychiatric crisis services are unevenly distributed across the province, and some of the available services provided by general hospital psychiatric units are inadequate. To overcome these inadequacies, it is recommended that each District Health Council's mental health plan provide for adequate child and adult psychiatric crisis services across the district and that the Schedule 1 mandate of general hospital psychiatric units be construed to include children and adolescents, as well as adults, and also backup services to Children's Mental Health Centres. It is also recommended that the Ministry of Health take appropriate action to enable general hospitals with psychiatric units to fulfill their Schedule I responsibilities and that general hospital emergency department staff be trained to recognize and manage patients in psychiatric crisis.

3.2 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Responsibility for these services is divided between the Ministries of Health and Community and Social Services. Adolescents 16 to 19 years old suffer most from this division of responsibility because of variable admission practices among psychiatric and children's mental health facilities. These years, 16 to 19, are the critical ones for the onset of major psychoses. The two ministries have established the Interministry Committee on Children's Mental Health Services which constitutes the basic interministry planning and co-ordinating mechanism.

The objective of the recommendations is to establish a provincial network of inpatient, outpatient and day care treatment services for children and adolescents. The roles and responsibilities of the two Ministries need to be clarified. A mechanism is required to encourage co-ordination between the two Ministries at the field or local level; a useful approach would be the establishment by the Ministry of Community and Social Services of Joint Children's Mental Health Services Planning Committees which would be located in the area offices of the Ministry of Community and Social Services and include representation from the Ministry of Health. It is also recommended that the Ministry of Health appoint a special consultant for children's mental health services.

3.3 REHABILITATION AND MAINTENANCE SERVICES

Major rehabilitation and maintenance services must include a place to live, educational/vocational rehabilitation, social/recreational and life skills training programs. These services are unevenly distributed across the province. The objective is to establish a continuum of rehabilitation and maintenance services ranging from major to minimum support programs. The primary at-risk populations requiring these services are the mentally ill person with reduced coping ability living in the community, and the psychiatric hospital patient who will be discharged, or could be discharged if community services were available.

With respect to a place to live, the recommendations include: improving the eligibility of the psychiatrically disabled for publicly-assisted housing; encouraging co-operative programs with the private sector and with third-sector housing programs; expanding the Homes for Special Care and Approved Homes Programs to include patients from all psychiatric facilities; and providing rehabilitation and maintenance programs for residents of these programs.

With respect to other rehabilitation and maintenance services, recommendations include: purchasing services funded by other Ministries such as Community and Social Services, Tourism and Recreation and Labour; expanding the availability of rehabilitation and maintenance services, particularly in underserviced areas, by funding them jointly with other Ministries; and carrying out Level of Care surveys in the provincial psychiatric hospitals to identify patients suitable for discharge and the services they will require when discharged into the community.

4.0 HUMAN RESOURCES

The major problem is that the distribution of mental health resources across the province, especially specialized resources such as psychiatrists, does not match either the distribution of the general population or the distribution of the particular groups which require those services. There is also an inadequate supply of professionals in specialized mental health fields, as well as professionals trained to serve certain sectors of the population. General practitioners provide the bulk of treatment for the mentally ill with a psychiatric diagnosis, and there are concerns about their training and the need for psychiatric backup. Volunteers represent a major pool of existing and potential resources.

4.1 HUMAN RESOURCE STRATEGIES

The thrusts of the recommendations are: (1) to increase the supply of professionals in those specialized areas of mental health services which are underserviced; and (2) to encourage the more specialized resources, such as psychiatrists, to place increased emphasis upon consultation and backup to other mental health care providers, including general practitioners.

Recommendations include: additional psychiatric residency slots in the child and adolescent, forensic, psychogeriatric and addictions fields; funding to link family practice units with psychiatric facilities, and other arrangements to encourage psychiatrists to place more emphasis upon consultation and backup to other mental health professionals; and more training programs for rehabilitation and maintenance workers, particularly in underserviced areas.

Similarly, mental health services for Francophones can be expanded by encouraging Francophones to apply for psychiatric residency slots, and by establishing training and development programs for Francophones in areas where there is a need for services in French. The recommendations also support the initiatives by the Ministry of Health regarding services to native people.

A Co-ordinator of Volunteers is required by the Ministry of Health to work with volunteers directly and also indirectly through other Ministries which have active volunteer facilitation programs.

4.2 UNDERSERVICED POPULATIONS

In underserviced areas the problems lie in attracting professionals and persuading them to remain. The Ministry has had increasing success over the past year or so with its Underserviced Area Program. Nonetheless, the long-term problems remain. The objective of the recommendations is to bring training and development programs to the people already living in the underserviced areas, rather than bringing the people to programs which are provided elsewhere.

The recommendations include: designating selected hospitals in underserviced areas as affiliated teaching hospitals with psychiatric residency slots to enable local general practitioners and others to train without having to uproot their families; extending nursing programs and non-medical teaching programs through similar means; and developing service models appropriate for areas where psychiatric and other resources are scarce.

4.3 HUMAN RESOURCE TRAINING AND DEVELOPMENT

There is no "mental health" discipline or profession. A number of professions are involved in providing mental health services and there is no core body of knowledge common to all these professions. Even within each of these professions, except for psychiatry, there are considerable variations in education, training and standards of practice. We need to bring greater consistency into education and training programs so that practitioners, employers and consumers have a better idea of the services they are purchasing.

A "Council of Therapists" or equivalent body is recommended to be responsible for establishing a classification system and code of ethics for mental health workers who practice various forms of therapy. The classification system would be developed in consultation with the affected professions and teaching institutions and communicated as a guide to mental health workers and consumers.

It is recommended that the "Ontario Mental Health Training, Development and Resource Centre", or equivalent body, be established for the development, co-ordination and delivery of orientation, training, skills upgrading and similar programs for those working in the mental health field. The Centre would consult with the professions and teaching institutions and direct programs to service providers, psychiatric hospital boards, managers and administrators, District Health Council members, civil servants, police, volunteers and others.

Both the Council of Therapists and the Resource Centre can be established as adjuncts to the Ontario Mental Health Foundation which already has the legislated mandate to provide these services.

5.0 SPECIAL ISSUES

5.1 PROVINCIAL PSYCHIATRIC HOSPITALS

No overriding provincial interest has been identified which requires that the Ministry of Health continue to own and operate the ten provincial psychiatric hospitals. There are two main issues to resolve: the relationship and accountability of the hospitals to the Ministry of Health; and their relationships to the agencies in the communities they serve. Once a provincial psychiatric hospital meets criteria defined by the Ministry, the divestment of that hospital should be possible.

It is suggested that divestment criteria include the preparation of a hospital program and services plan including inpatient, outpatient and day care services consonant with the various district mental health plans in its area, and demonstrated competence of hospital management and staff to carry out the responsibilities of an autonomous hospital. The roles of some of the hospitals' front-line staff may change and consultation should take place with the Ontario Public Service Employees Union.

In the meantime, some provincial psychiatric hospitals have to improve their standards of management and practice. It is recommended that each hospital prepare a statement of philosophy, management and patient care, taking into account the mental health plans of the health districts it serves and the need to create a work environment conducive to job satisfaction; that hospital Community Advisory Board members, administrators, medical and program directors and managers should be required to meet stipulated standards of performance; and that funding for hospital medical staff be more competitive to attract highly qualified staff.

The concerns raised about the role of the Patient Advocate in the provincial psychiatric hospitals suggests that the Ministry define their roles and responsibilities more precisely. They need to have a demonstrated understanding of mental illness, treatment and patient care. The Advocate's access to patient files needs to be governed by guidelines which respect confidentiality and the protection of third parties.

5.2 THE STATUTORY FOUNDATIONS AND MENTAL HEALTH SERVICES

Closer co-ordination is required between the Ministry of Health and the Ontario Mental Health Foundation (including the Clarke Institute of Psychiatry) and the Addiction Research Foundation, and between the two foundations themselves. This can be defined through Memoranda of Understanding.

The research funding allocations of the Ontario Mental Health Foundation need to be reviewed as does the composition of its Medical Advisory Board. The Foundation will require increased resources to carry out the tasks proposed for it in this Discussion Paper.

It is also recommended that a research co-ordinating mechanism be established by the Ministry to review and approve all proposals for mental health research prior to their submission to the Health Research and Development Council of Ontario.

5.3 SPECIALIZED SERVICES

5.3.1 Forensic

Forensic psychiatric services are unevenly distributed, responsibility is fragmented amongst several Ministries and there is a need to separate the non-forensic from the forensic populations in provincial psychiatric hospitals.

A special observation unit for the difficult behavioural non-forensic patients is required in each provincial psychiatric hospital. For forensic patients, at least one medium secure unit is required in each health region, and the Oak Ridge unit at Penetangui hene Mental Health Centre, properly refurbished, will continue as the provincial maximum secure unit. To ensure integrated services, each regional medium secure unit should have a regional advisory committee. This committee would consist of representatives from the participating Ministries and other organizations and the primary responsibility of the Ministry of Health would be for assessment and treatment services.

It is also recommended that a provincial advisory committee plan and co-ordinate overall forensic service delivery, research and education, and that a provincial centre of excellence in forensic psychiatric services be established utilizing the resources of the Clarke Institute of Psychiatry and METFORS.

5.3.2 The Developmentally Handicapped

Services for the mentally ill developmentally handicapped are unevenly distributed across the province and there is a scarcity of resources for this group. The Ministries of Health and Community and Social Services need to clarify their respective responsibilities in this service area.

Requirements for this group include: secure long-term setting for treatment and care to be provided by the provincial psychiatric hospitals for the aggressive, seriously disturbed; at least one general hospital psychiatric unit in each health district should be designated to provide short-term psychiatric inpatient treatment to those developmentally handicapped who require this service and also provide consultation to community agencies to help them help the developmentally handicapped who live in the community. Other recommendations include the appointment by the Ministry of Health of a special consultant in psychiatric services for the developmentally handicapped.

5.3.3. Psychogeriatrics

As the population ages, the demand for psychogeriatric services will continue to increase. The field of psychogeriatrics has not attracted sufficient numbers of psychiatrists and other resources, and co-ordination between the Ministries of Health and Community and Social Services needs to be improved.

The recommendations are intended to establish a network of psychogeriatric services, organized at the district level, across the province. Professional staff will need additional training in psychogeriatrics. The recommendations include: more psychogeriatric residency slots and training programs; more emphasis on psychogeriatrics in the curricula of mental health professionals; the designation of a Health Sciences Centre to become a provincial centre of excellence in the field of psychogeriatrics; and the appointment by the Ministry of Health of a special consultant in psychogeriatrics.

Because psychogeriatric patients often have medical as well as psychiatric problems, it is important to co-ordinate medical and psychiatric treatment with accommodation and support services. The objective is to allow individuals to move in and out of acute medical and psychiatric care settings as their condition requires. It is recommended that District Health Councils encourage the development of such multiservice programs for psychogeriatrics; that at least one general hospital psychiatric unit in each health district be designated to provide psychogeriatric assessment and treatment services; and that the Ministry of Health establish a pilot project in which assessment, treatment, accommodation and support services are co-ordinated by a general hospital.

5.4 PREVENTION

Primary prevention programs in mental health are essential if we are to place some reasonable limits on the increasing demand for mental health services. Primary prevention programs in mental health are difficult to design and first priority should be given to building upon the experience of programs which have had demonstrated results. These programs involve physical fitness, employee assistance and health and lifestyle promotion. Because of the large number of government, non-profit and private companies involved in these programs, a Ministry of Health special consultant in primary prevention in mental health will be needed for consultation and liaison.

Three target groups are proposed: persons in the workplace, residents of at-risk communities and children and adolescents. Workplace programs will have to be co-ordinated with the Ministries of Community and Social Services, Tourism and Recreation, Government Services and Labour as well as with programs carried out by the Addiction Research Foundation and other organizations and private companies already involved in this field.

It is also recommended that the Ministry of Health establish with other Ministries a pilot project in an at-risk community to test the effectiveness of various primary prevention programs, and consult with other Ministries concerning appropriate primary prevention programs in mental health for children and adolescents.

FOREWORD

The Ontario Council of Health's Agenda for Action report (1979) recommended that the Ministry of Health appoint a co-ordinator of mental health services. As a consequence, in June 1981, I was appointed by the Ministry to review and assess the current state of mental health services in the Province of Ontario and to recommend policy directions for the future development and delivery of these services.

The mandate was broad. Consideration was to be given to all aspects of mental health services in Ontario, including the organization, delivery and program content of services provided by and through the following: the psychiatric units of general hospitals, the provincial psychiatric hospitals, the Homes for Special Care Program and other residential and after-care programs, the Ministry's Adult Community Mental Health Program, and community-based and volunteer agencies. In considering the above, an examination was also requested of the relationships between the Ministry of Health and other ministries which might be involved in the provision of services to the mentally ill. In addition, the work and recommendations of the Ontario Council of Health's Committee on Mental Health Services in Ontario (Agenda for Action, 1979) were to be reviewed.

This project was begun with the conviction that field observation and consultation, along with a review of the literature, are valuable techniques for obtaining an understanding of how a health service delivery system operates. Every effort has been made to document my findings with data. Where data have not been available, the advice of persons experienced and knowledgeable in the field of mental health has been relied upon.

Considerable time was devoted during the first year to visiting a wide variety of mental health care consumers, providers and planners across the province. I travelled from

Attawapiskat on James Bay to Windsor, and from Kenora in the west to Cornwall in the east, consulting with psychiatrists, family practitioners, nurses, hospital administrators, District Health Councils, representatives of professional associations, O.P.S.E.U., and advocacy groups (see Appendix C). Out-of-province trips were made to examine the work being done in Vancouver, Montreal, and New York.

To make clear the professional background which I bring to this study, I am the chairman of a department of psychiatry and a practising clinician. I also want to note that during 1982-83 I chaired the Medical Advisory Board of the Ontario Mental Health Foundation, having been a member of the Advisory Board prior to that. I have benefitted from my association with the OMHF, and do not believe that this association has unduly influenced my recommendations. In addition, in 1977-78, I conducted an investigation of the health care delivery systems in several European, Middle Eastern, African and Asian countries, under the joint sponsorship of the Faculty of Medicine, University of Western Ontario, and the Ontario Council of Health with the assistance of Health and Welfare Canada and the World Health Organization.

During the latter half of 1981, as a background study for this paper, Dr. Alex Richman, Mr. Peter Roberts and I carried out a review at the Whitby Psychiatric Hospital. Given the mandate to recommend directions for the future development of mental health services, it was appropriate to evaluate the function of that facility. The main component of the Whitby study was a Level of Care Survey conducted to assess the clinical and accommodation needs of the hospital's patients. The results of this survey indicated that a substantial portion of the inpatients of that facility were suitable for care provided in a non-hospital setting.

A general review of the literature with special emphasis on recent studies and reports on mental health services in Ontario was also completed during the first year. A full list is included in the Bibliography.

Throughout the first year, representatives of other provincial ministries whose jurisdictions include services which are or may be delivered to the mentally ill, and, of course, members of the Ministry of Health's staff, were consulted on an ongoing basis.

During the latter half of 1982, in order to encourage and obtain feedback, an interim report with preliminary recommendations was drafted. In early 1983, this discussion document, Blueprint for Change: The Next Ten Years, was circulated widely. A series of formal consultation meetings was held subsequently in each of the ten provincial psychiatric hospital catchment areas. Representatives were invited from consumer groups, official local health agencies, local branches of the Canadian Mental Health Association, general hospital psychiatric units, Health Sciences Centres, District Health Councils, community psychiatric hospitals, The Ontario Hospital Association, provincial psychiatric hospitals, their Community Advisory Boards and other organizations. Numerous discussions were also held with representatives of specific interest groups, including concerned unions, who wished to respond directly to the interim report. The many written responses were read and considered (Appendix D).

This consultation process was a valuable component of the overall project. Many of the interim report recommendations have been modified, some of them substantially, to take into account this feedback. For example, the concepts of the pivotal hospital and the public health nurse as case manager were of interest to a great many people and these concepts have undergone some modification as a direct result of the consultation process.

There is a large number of persons who contributed directly or indirectly to this project and whom I wish to acknowledge. I am very grateful to Dr. M. Hollenberg, Dean of the Faculty of Medicine, University of Western Ontario, and to my colleagues in the Department of Psychiatry, especially those at the University Hospital in London for their tolerance and continued support during my absences.

The cooperation and assistance of the Ministry of Health and its staff were absolutely vital to the completion of this report. The Ministry of Tourism and Recreation should also be acknowledged for permitting the incorporation of materials from their studies in a background paper on employee health promotion programs.

I am most grateful to Mr. Peter Roberts, Senior Planning and Research Officer on this project, for his on-going personal support and commitment to this project and especially for his concern for and empathy with the individuals who are the subject of this project.

Dr. Alex Richman made a major contribution to the historical review and epidemiological basis of the interim report which was the precursor of this document. Dr. Barrie Humphrey of McMaster University was of great assistance with advice and as a resource person in mobilizing data throughout the course of the project. Mr. Mark Hundert and Mr. Tom Clossons of Medicus Canada generously provided reference materials and data during the latter stages. The generous assistance of these four gentlemen is gratefully acknowledged.

Many skills are required in the preparation of a document such as this. Ideas and concepts remain only that unless they are carefully brought together in a form that allows the perceptions of the author to be clearly understood by the reader. Earl Berger and Dianne Macfarlane undertook the complex task of organizing a mass of material and presenting it as a coherent whole. Dr. Berger not only brought his considerable drive and talents to this task but, along with Leslie Pearl, he also prepared the background paper on preventive mental health in the workplace. I am in his debt. The personality, energy, skills and initiatives of Dianne Macfarlane were of extraordinary help in collecting, verifying and synthesizing a myriad of facts and concepts and are most gratefully acknowledged.

Elizabeth Chandler has been my secretary for the past two years during a project that necessitated my carrying out responsibilities in two cities and visiting many centres across the province. I am most appreciative of her initiative, diplomacy and loyalty which made my task much easier. I also want to thank Deborah Mason for her untiring efforts in the typing of the many revisions of this Discussion Paper.

Finally, my thanks to Doreen Bayley, my executive assistant, and Wendy Foster, my secretary, in my London office for carrying on so ably and effectively, with patience and humour, during my frequent perambulations.

SECTION I

INTRODUCTION

INTRODUCTION

In this project, the primary concern has been the following: in the community there are persons suffering from problems associated with mental illness and others with the desire and skills to alleviate that suffering. The fundamental goal is to bring these two groups together and to ensure that, as necessary, an appropriate array of support services are available. One must recognize that the two most important people in this arrangement are the mental health client or patient and the primary mental health care professional. We always have to ensure that the needs of these two people, particularly the client or patient, are predominant and that the "system" contributes to the availability and quality of treatment and care.

Let me comment first on the contentious issue of "mental illness".

There is no universally accepted definition of mental illness. It is a generic term used to characterize a broad range of behaviours and mental postures(1). The World Health Organization has defined health as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". Although I agree philosophically with this definition, such a state is not easily achieved. A more functional definition is that mental health is "a style of living that allows the individual to develop his abilities to pursue goals, to meet needs, and cope with life-problems without undue emotional distress" (C.M.H.A./Ontario Division, 1981a:5). For purposes of this Discussion Paper, it is assumed that mental health services are required when a person's mental state is such that it hampers or impedes his or her ability to cope to such an extent that family and friends are unable to help.

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(1) Leighton (1982:6) describes the heterogenity of mental illness as follows: "the categories (of mental illness) range from brain syndrome through psychoneurosis to personality disorder; the causes include many different combinations of genetic, traumatic, infectious, nutritional, degenerative, psychological, societal, and cultural factors; syndromes vary widely in the degree to which the causes are dependably known, with general paresis at one extreme and personality disorders at the other; the degree of disability ranges from slight to total; dangerousness ranges from none to great; duration runs from transient situational disorders to life-long psychoses; frequency in populations ranges from the rare fou savant to exceedingly common patterns of anxiety and depression; and treatability extends from good responses to reassurance and medication to intractability in the face of every known remedy."

It is estimated that one out of every seven persons will, at some time in his or her life, seek assistance for a mental health problem. Or, viewing it from another dimension, it is suggested that, at any one time, 15 per cent to 25 per cent of the population require some form of mental health care: informal, generic or psychiatric. Not all of them, of course, require psychiatric treatment and care.

I approached this project with a number of convictions. One is the belief that it can be antitherapeutic to maintain a mentally ill person in an institution unless the medical or behavioural components of the actual illness dictate doing so. The debilitating effects of long-term hospitalization on the mentally ill have been well documented (e.g., Barton, 1966; Goffman, 1961; Gruenberg, 1969). In addition, a review of the literature on the Canadian and American experiences of deinstitutionalization suggests that chronic mental patients fare no worse and sometimes fare better in the community than in institutions when adequate support is provided (e.g., Barnes and Toews, 1983; Test and Stein, 1978). The length and type of psychiatric hospitalization can also stigmatize an individual, making his or her acceptance back into the community even more problematic than it need be. The value of treating the mentally ill person as much as possible in the community in which he or she resides has been accepted by most mental health professionals. I share this belief.

Thus, I support, in general, a continuation of the shift away from the treatment and care of mentally ill persons in large, often remote, institutions, and toward treatment and care provided in the local community. The overall goal of the recommendations in this Discussion Paper is to promote the continuation of this shift to a decentralized mental health care system, incorporating a comprehensive range of services provided in a continuum of environmental settings within the community to meet the health, social, and vocational/educational needs of the individual in a just and effective manner. In such a "balanced"(1) service system, psychiatric hospital facilities are only one of the numerous important community resources which should participate cooperatively in the provision of mental health services.

Such a mental health care system emphasizes non-institutionalization. Energy and resources are directed toward preventing mental illness and reducing the need for hospitalization among those who do require mental health care. This emphasis on non-institutionalization can both avoid the incapacitating effects which often accompany institutionalization and increase community acceptance of the mentally ill.

The dollars available for health care, including mental health care, are not unlimited. One of the factors which hinders the development of an effective mental health treatment and care system is that we have tended to espouse too many goals and to choose too few priorities. As Leighton (1982:16) succinctly puts it, "the core of the issue is the management of limited resources, of making choices among many different kinds of humane goals".

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(1) My understanding of the "balanced service system" concept was aided greatly by examining the U.S. Joint Commission on Accreditation of Hospitals' model as discussed in Schulberg et al, 1979.

In a mental health care system there is competition for resources among different kinds of users. Therefore, the assignment of priorities is essential. It certainly seems reasonable, particularly in the current economic situtation, to direct our energy and attention to those persons who are suffering from acute and serious mental disease and to that portion of this group which suffers from long-term psychiatric and psychosocial disabilities, including reduced competency or ability to cope.

It is desirable to protect mental health services from being so overwhelmed with an increasing breadth of demands for care that the services are unable to give adequate attention to persons who most need them. Cumming (1979) has developed a model for approaching the difficult but crucial question of priorizing mental health needs. He categorizes people seeking mental health services according to the type and severity of the mental illness in descending order of seriousness and, hence, of priority as follows:

1) the disabled (for example, chronic psychotics);
2) the diseased (for example, acute psychotics);
3) the distressed (for example, neurotics);
4) the dissatisfied (for example, the bored and alienated who are neither disabled nor ill but may be seeking mental health services).

Leighton (1982) recommends an approach to priorities which adds the dimensions of prevalence and treatability to that of the degree of disability created by the mental illness. Implied in the establishment of priorities is the recognition that not all individuals, or groups, can be served with equal attention or resources.

In reviewing and assessing the current state of mental health services across the province, it is apparent that there are two groups of patients who are having difficulty obtaining the services they need, namely:

1) those who are in crisis;
2) those who are disabled by a mental illness and require continuing support other than long-term institutional care.

Within the treatment component of mental health care, the availability of crisis services continues to be a major problem. Some District Health Councils have identified crisis services in their areas as deficient and have ranked it as a priority for action. The situation for children in crisis is perhaps even more problematic. Many children's mental health centres are not seven-day-a-week, 24-hour-a-day operations. The family of a child or adolescent who is experiencing a crisis often experiences very real difficulties in obtaining appropriate crisis service.

Some number of the mentally ill population are disabled; that is, they are functionally impaired and need assistance in gaining access to the most basic of life's entitlements. They require a place to live in a setting with the appropriate amount of support and access to a spectrum of treatment and rehabilitation or maintenance services. For some of them, periods of hospital care continue to be a necessity. It is for these persons that the issue of continuity of care is a major problem.

For many seriously mentally ill persons who have been hospitalized, the real suffering begins after discharge. Aftercare and rehabilitation services can spell the difference between remaining in the community and being rehospitalized. For both those mentally disabled who are presently in the community and for those who could be discharged to the community in the future, the adequacy of support services is crucial.

The issue of whether a mental health care system is derived from either a "medical" or "non-medical" model is a controversial one. During the discussions with service providers and consumers across the province after the interim report was circulated, this issue was often the subject of intense debate.

I am a psychiatrist and admittedly have a "medical treatment" bias. The professional literature definitively substantiates that some proportion or number of mental health service users require medical treatment. The precise proportion or number is, perhaps, open to debate, but the medical treatment approach is undeniably the most appropriate for these people. For example, the major functional psychoses and affective disorders are very definite medical illnesses with mainly, although perhaps not solely, biochemical and genetic components (e.g., Henn and Nasrallah, 1982; Baldessarini, 1983). Since this is so, physicians and hospitals have the responsibility to keep certain symptoms and behaviours under control in order to bring the individual to the point where he or she can begin to cope on their own with the help of support services. Despite the important advances in our understanding of the biological and genetic abnormalities underlying these major psychoses, the processes involved in these abnormalities remain largely obscure. Consequently, while our treatments today are more effective than ever before in 'controlling' psychotic symptoms, our treatments are not yet entirely 'curative'.

It also has to be acknowledged that in a number of cases the demarcation line is blurred between those who require a medical treatment component and those who do not require this approach. Further, it is recognized that those who do require specific medical treatment may have an increasing need for psychosocial care and support services as the medical intervention is reduced.

Consequently, to view the provision of mental health services on the basis of an either/or medical/non-medical model does a disservice to those who need such services. I prefer to think in terms of a continuum of services for those who need mental health care. Some of these needs are "medical", others quite clearly are not. Therefore, the medical vs. non-medical issue is a non-issue, once it is clearly recognized that a comprehensive mental health care service system must provide for both the medical and non-medical needs in order to accommodate the wide range of disabilities and levels of dysfunction.

Controversy is often generated over the related issue of the roles of the "hospital" and the "community" in the provision of mental health services. The use of the descriptives, "hospital/ institution-based" and "community-based", to denote where the bulk of services is provided tends to polarize providers and distract them from the more important consideration of the continuity of care provided through a continuum of services and environments. For example, the general hospital psychiatric unit is a resource based in and owned by the community or, as some would say, a community-based service. Although it may not always be as sensitive and responsive to all the needs of the community as one might wish, it nonetheless constitutes an important component of the total community mental health delivery system.

A common notion of "community" appears to exclude the hospital or to view non-hospital programs based in the community as an alternative, and a superior one at that, to existing hospital (both psychiatric hospital and general hospital psychiatric unit) programs. This point of view can have harmful consequences. One has only to look at some American jurisdictions where psychiatric hospital facilities have been replaced to a large extent by "community" mental health programs to see the results - the chronically mentally ill have often been overlooked. (e.g., Bachrach, 1976 and 1980; Gruenberg and Archer, 1979).

As Wattie (1982:25) has pointed out, there is a continuing need, at least for the foreseeable future, to develop and ensure good programs in institutional settings. The British experience has clearly demonstrated that there is an irreducible minimum number or segment of the mentally ill who will require long-term hospital care (Wing and Olsen, 1979).

Therefore, the distinctions between hospital/institution-based and community-based services are not useful. We should not be so seduced by the excitement of developing "community" (in the sense of non-hospital) programs that we neglect the need to maintain active interest in the quality of our psychiatric facilities.

One can speak, however, of a community-based service system: a range of mental health services located and coordinated within certain geographic boundaries to respond to the needs of and be reasonably accessible to persons living within those boundaries. Such a system is tailored to meet local community needs. That is the objective, and we must not permit debates over "hospital versus community", often ideological in nature, to distract us from developing a balanced mental health care system.

Another matter raised frequently during discussions across the province was that of government expenditures on mental health services. As the Taylor Committee Report (1977) noted, health care in Ontario is a loosely-structured undertaking with splintered responsibility and a myriad of decision-making mechanisms which can result in a misuse of facilities, duplication and waste. This observation applies to mental health care as well. The difficulty is that mental health services cover such a wide array of responsibilities and activities. For example, mental health, as described below in the Current Situation (see also Chart AIII-1 in Appendix A), involves the federal, provincial and municipal levels of government; at the provincial level, it involves a number of ministries, within the Ministry of Health itself, it involves divisions, and at the community level it involves hundreds of hospitals, agencies and associations, as well as thousands of medical and other professionals. Splintered responsibility, and its consequences, are inevitable in these circumstances. Consequently, given the current economic situation, we must, now more than ever, make every effort to ensure that the impact of the money spent on mental health services is not diluted by the inappropriate use of expensive facilities, duplication or waste. In short, we must make every effort to make the best possible use of existing resources.

Recent Ministry of Health policy statements and initiatives are very much in phase with the thrust of suggestions discussed early in the course of this project. Internally, institutional (provincial psychiatric hospitals) and community mental health services have been regrouped and brought together under one Assistant Deputy Minister in December, 1981. In order to co-ordinate the operation of the planning for this wide spectrum of services, a Mental Health Division was formed within the Ministry in the fall of 1982.

In addition, the Ministry of Health has assumed the role of "lead Ministry" on behalf of the Ontario Government for all initiatives affecting adult mental health and the care and treatment of the mentally ill in the province whether those patients are staying in institutions or living in the community. As explained by the Minister (Grossman, May 29, 1982), this means that in areas where the Ministry of Health does not have direct responsibility, such as housing and social services, the Ministry will ensure that patients' non-medical needs for such services are brought to the attention of the appropriate provincial ministries, agencies, or municipal and federal governments. It is important to note also that the Minister indicated (Grossman, May 19, 1982) a willingness to accept responsibility for psychiatric patients after their hospital discharge, a new direction for the Ministry. Several other initiatives have been undertaken within the last year or so and will be detailed in subsequent sections of this report.

It has been impossible to give equal attention to all aspects of mental health care. Some issues are more fundamental than others to the development of a balanced mental health care plan. An attempt has been made to deal in some depth with each of the five major issues which the Agenda for Action report (1979) identified as deserving priority attention: co-ordination and decentralization, statistics and information, the management of psychiatric hospitals, French-language services, and services for Northern Ontario. In addition, as indicated above, two target populations have been identified for whom appropriate services must be assured: those requiring "crisis intervention" and those requiring "continuing support".

In introducing this Discussion Paper, the difficulty must be noted, as others before have, of obtaining data to illuminate important questions, such as how people actually use available mental health care services. Much of the information needed to plan, evaluate and monitor mental health services and programs is not easily accessible or not available.

Many readers are likely to experience a sense of deja vu when considering this Discussion Paper and its recommendations. Indeed, no claim for originality is made. Many have already heard me quote Goethe who said, "It has all been said before. Our task is to think about it again"; or, as another astute observer suggested to me "If you think you have an original idea, you haven't searched the literature adequately". A dramatic illustration of this truth was brought to my attention recently. In the interim report I argued, somewhat innovatively I thought, for the separation of treatment and accommodation services. However, Dr. Benjamin Workman, the first medical superintendent of the first Provincial Lunatic Asylum in Upper Canada, confronted with overcrowding in the Toronto institution in the 1860s, also recommended a form of separation of treatment from accommodation. (Annual Report of the Board of Inspectors of Asylums, Prisons for 1865; Price, 1950; Baehre, 1976). We are still struggling with the problem.

Mental health services in Ontario have been the subject of numerous studies and reports over the last ten years. Progress has been made, particularly in the last two years. Much remains to be done. It is my fervent hope that this Discussion Paper will assist in that endeavour.

SECTION II

BACKGROUND

1.0 PRE-1960

For most of the history of mental health care delivery in Ontario, as in most other North American jurisdictions, government-owned and operated mental hospitals have been the major site of treatment and care for the mentally ill(1).

Asylums for the care of the insane began to be built in Ontario during the second half of the 19th century. The first provincial "lunatic asylum" in Upper Canada began admitting patients in Toronto at 999 Queen Street in 1850(2). These asylums became vast buildings with large dormitories, generally some distance from the nearest community, with extensive attached acreage used for farming purposes and often situated on a lake(3).

Historically, the public mental hospitals performed multiple functions: they provided treatment and care for the severely mentally ill, discharging as rapidly as possible those who were at an early or reversible stage of mental illness; they cared for and protected those whose unacceptable behaviour, symptoms or disorder persisted; they provided permanent shelter and asylum for those without homes and friends; and they safely kept those from whom the community needed protection. These multiple functions - treatment, shelter, asylum, and custody - were performed for diverse clinical populations all under one administrative "roof". In addition to the "insane", the asylum population included criminals, vagrants, the retarded, physically ill persons, and others considered unfit for society at large. The majority of these persons were poor.

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(1) The history of mental health in the Province of Quebec evolved in a different fashion. Up to the early 1900s, it was the religious orders which operated the large hospitals for the care of the insane (Heagerty, 1928:258).

(2) The second Provincial Lunatic Asylum was opened in Kingston in 1856 and the third in London in 1870 (Hurd, 1917).

(3) The average bed capacity of Ontario mental hospitals built prior to 1960 exceeded 1,000 (Hanly, 1970:143). For example, the Provincial Asylum in Whitby was built in 1916-17 on 640 acres of lakeshore property with a capacity of 1,500 patients (Hurd, 1917:185). This pattern is demonstrated in data reported by Richman and Harris (1983:65) which indicated that for each patient, mental institutions in 1931 had 0.57 acres of land and raised $26 of garden produce.

During the early stages of their development, each asylum employed the services of a small staff. For example, it is reported that in 1878 there were approximately 390 patients under the care of 14 attendants, called "keepers", and seven nurses at the Rockwood Asylum in Kingston (Kingston Psychiatric Hospital, 1981:13). However, as the 19th century progressed, the issue of ever-increasing crowding became a problem for asylum medical superintendents (ibid.:17).

As the patient population in the mental hospitals continued to increase during the first half of the 20th century (Hanly, 1970:139), custodial care became the key response to the management of the mentally ill and this response remained essentially unchanged into the 1950s. Active treatment methods during these latter years were, for the most part, limited to insulin, electro-shock therapy and sedatives. Many patients did not respond to treatment, and many who did respond obtained only partial relief from their symptomatology. Long-term confinement was, therefore, not unusual, particularly because there were limited treatment and accommodation options available in the community.

Psychiatric care in 1948 has been described by the Department of National Health and Welfare as the era of the "snake pit" mental hospital - bars, locks, restraints and "herding" of patients (Richman and Harris, 1983:65). The prison-like "warehousing" of an increasingly large hospital population of mentally ill was due partly to the fact that these institutions were "tragically understaffed" and "operating on a shoe-string budget" (Jones, 1967:14). Mental hospital reports persistently noted the problem of the "chronic patient" for whom hospital care was no longer essential but for whom no other accommodation was available.

Beginning in 1932, pressure on Ontario psychiatric hospitals was relieved to some extent by the provision of "Approved Homes". Only inpatients of these hospitals were eligible and the homes provided long-term accommodation for some chronic patients, and transitional accommodation for others. Program support and resident contact with professional staff were almost non-existent.

A stigma was attached to being hospitalized in psychiatric institutions, and, therefore, patients and their relatives tended to use them only as a last resort. Given, however, the small number of alternative sites for treatment, many mentally ill persons, particularly those with few resources in this period prior to universal health insurance, had little choice about where to turn for help. The psychiatric hospitals became the depository for the socially and economically disadvantaged segments of the mentally ill population.

The psychiatric hospital system in Ontario continued to expand from the late forties to the late fifties in an attempt to combat serious overcrowding. For example, by 1948 the Rockwood Asylum had 1,217 patients listed on the books in a hospital designed for less than 800 (Kingston Psychiatric Hospital, 1981:40). Although the number of patients per hospital increased substantially during this period, the staffing of public mental hospitals also increased and doubled between 1948 and 1959 (Turner and Avison, 1983:277). The psychiatric hospitals remained the primary locus of treatment but general hospital psychiatric units began to appear (there were 11 such units by 1959). In addition, during the 1950s some of the psychiatric hospitals established outpatient and travelling clinics (Ontario Department of Health Annual Reports; Wilson, 1982:3). These two developments foreshadow the substantial change which has occurred in the nature of Ontario's mental health care delivery system in the last 25 years.

2.0 POST-1960

During the 1950s, health care systems in western countries began to take a hard look at mental illness and mental hospitals. The gradual shift in emphasis during the last 25 years away from the provision of custodial care in large mental institutions was stimulated and facilitated by the development of psychotropic medications. Several of these new drugs were introduced in Ontario's psychiatric hospitals in 1954 on a clinical trial basis (Ontario Department of Health Annual Report, 1954:32). By 1961, psychiatric hospitals were using these drugs extensively in the treatment of both inpatients and outpatients (Ontario Department of Health Annual Report, 1961:74). These medications were effective in controlling many of the symptoms of mental disorder so that, even in the case of the seriously mentally ill, patients could be hospitalized for shorter periods, or could be treated on an outpatient basis. In addition, many chronic or long-term patients could be discharged from the mental hospital. Although they were not cured, their behaviour was modified sufficiently by the medication to allow, in many cases, for community acceptance. Acceptable behaviour encouraged earlier discharge which, however, often occurred without a full appreciation of the support services required.

A number of important developments have occurred since the early 60s: the size of the psychiatric hospital inpatient population has decreased steadily; at the same time the use of the general hospital psychiatric unit has increased; the "community" mental health movement has evolved; and universal health insurance has become available. Each is discussed in turn.

2.1 DEINSTITUTIONALIZATION

As a result of therapeutic advances and changing treatment philosophies, there has been a major decrease in the size of the psychiatric hospital population over the last 25 years. This has happened in every province in Canada (e.g., Kedward et al, 1974; Barnes and Toews, 1983:22).

This decrease is primarily the result of a decline in the mean length of stay for patients in mental institutions. By 1960, 0.4 per cent of the Canadian population were in mental institutions; of these 75,000 persons, one-half had been hospitalized for more than seven years (Richman and Harris, 1983:65); death in hospital was more likely than discharge for the long-stay patients (ibid.). Between 1960 and 1976, the bed capacity of Canadian mental hospitals decreased from 47,633 to 15,001 (Richman and Harris, 1983:70) and during 1976-77 most psychiatric hospitalizations were relatively brief - 65 per cent of psychiatric discharges spent less than one month in hospital (i.e., a mean stay of 13.2 days) (Richman et al, 1982:19). Nine out of ten discharges spent less than four months in hospital (i.e., a mean stay of 25.7 days) while 97 per cent of the discharges involved psychiatric care for under 12 months (a mean stay of 33.7 days) (ibid.).

A similar trend is reflected in Ontario during the last 25 years. The total number of inpatients in Ontario provincial psychiatric hospitals peaked in the years 1959 through 1961, after which there began a steady decline with the largest decreases occurring in the years 1965 through 1968(1). The total number of Ontario Hospital

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(1) The data on which this analysis is based were collected from Ontario Department/Ministry of Health Annual Reports for the years 1959 through 1975.

(as the provincial psychiatric hospitals were described then) beds was approximately 16,000 in the early 1960s. This figure included the Ontario Hospital schools for the mentally retarded which were at that time under the jurisdiction of the Ministry of Health (Wilson, 1982:3). But, by the end of March 1982, there were only 4,514 patients on the books of provincial psychiatric hospitals and during that year there was an average daily population of 3,919 (Ministry of Health, Hospital Statistics, 1981/82).

As the population of the public mental hospitals decreased, the number of admissions increased, due primarily to a substantial increase in the number of readmissions(1) (Table II-1).

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(1) In the U.S., it is also reported that readmissions rose sharply during the 1950s and 1960s (Goldberg and Huxley, 1980:133; Gruenberg and Archer, 1979:499).

Table II-1

Ontario Public Mental Hospitals: 1960 and 1976

	1960	1976
First admissions	4,575	5,433
Readmissions	3,664	8,886
Total admissions	8,239	14,319
Discharges	6,426	14,365
Deaths	1,629	341
Total separations	8,055	14,706
Bed Capacity	15,141	5,314

Source: Health and Welfare Canada

Twenty-five years ago, the number of inpatients in each provincial psychiatric hospital was often three to four times what it is today, while total staffing was often less than current levels. A comparison of total staff paid hours per patient day (1983 versus 1958) indicates that the total paid hours per patient day has increased by four to six times in the past tweny-five years (Medicus Canada, 1983:40).

The increase in the level of staffing, some of which was necessitated by increases in outpatient activities(1), is one factor in explaining another phenomenon which has occurred during this period. While the number of psychiatric hospital beds has been reduced, the size of the psychiatric hospitals' budgets has not. Indeed, as Gruenberg and Archer (1979) noted in their analysis of the American deinstitutionalization experience, the period of census decline in mental hospitals has been accompanied by increasing budgets.

In Ontario, the reduction of the mental hospital population was partially effected by the transfer of patients who neither required nor received active treatment to either newly designated "residential units" or to "Approved Homes". Between 1952 and 1965 the number of patients in "Approved Homes" more than doubled, from 735 to 1,688 (Ontario Department of Health Annual Reports).

In 1964, an insufficient supply of such places to cope with the demand for placements occasioned the passage of the Homes for Special Care Act. These homes for discharged psychiatric hospital patients ranged from approved lodging houses and licensed nursing homes to licensed residential care. The nursing home component of the Homes for Special Care Program grew steadily until it peaked in 1976 (from 1,621 residents in 1965 to 5,715 residents in 1976), leveled off in the late 1970s and has experienced a slight decrease more recently. The residential home component began on a much more modest scale (47 residents in 1965) and has continued to grow. By 1981, 2078 residents were being cared for in the program's residential homes. Overall, between 1965 and 1981 an estimated 15,000 patients whose primary needs were accommodation and board were transferred from the psychiatric hospitals to these nursing and residental homes.

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(1) Some psychiatric hospitals did allocate new resources to out-patient and community outreach programs. Others, however, remained insular and confined their activities to mainly inpatient populations.

In response to the decline in psychiatric hospital inpatient numbers, the government closed several public institutional facilities during the mid to late 1970s:

1) Goderich Psychiatric Hospital with 204 beds and Northeastern Regional Mental Health Centre (South Porcupine) with 147 beds were closed in 1976;

2) Dr. Mackinnon Phillips Hospital (Owen Sound) with 200 beds in 1978;

3) Lakeshore Psychiatric Hospital (Toronto) with 409 beds in 1979.

The patients in these hospitals were discharged to a variety of settings: nursing homes, Homes for Special Care residential beds, general hospital psychiatric units, other psychiatric hospitals and the community. The decision to discharge a patient into the community was often made without a full appreciation of the support services required and the impact of that discharge both on the patient and on the community.

The therapeutic advances which permitted increasing numbers of patients to be discharged from the psychiatric hospitals during this period, however, have not been paralleled by similar advances in the development of aftercare services.

Indeed, up to the mid-1970s, only a limited effort was made by the formal mental health care system, with the exception of the Homes for Special Care Program, to develop a network of support services for ex-psychiatric hospital patients discharged to the community. Although not requiring the level of care provided in a psychiatric institution, many of these ex-patients were and are disabled and experience alienation and difficulty in maintaining themselves in the community because of their reduced competency and ability to cope.

As is commonly the case, the chronically ill individual bears the brunt of changes in mental health policies and practices (Leighton, 1982:14). In some American jurisdictions where the deinstitutionalization movement eschewed the functions of custody and asylum, it has become apparent what the corollary may be - the neglect of the chronically mentally ill patient (e.g., Bachrach 1976 and 1980; Gruenberg and Archer, 1979). The dismantling of hospitals which performed these functions has not eliminated the need for these functions to be performed. Bachrach's analysis (1980:1025) is compelling: "Much of the difficulty associated with deinstitutionalization efforts may be attributed to the tendency of program planners to overlook, or to neglect to stress, the need for providing out-of-hospital alternatives for the full range of functions performed (previously) in hospital settings".

A relatively small proportion of the discharged psychiatric hospital population require many of the support functions which they used to receive in the hospital setting. Schizophrenia and the affective disorders are the major contributors to the chronic mentally ill population. Using Statistics Canada data on institutional admissions and separations in 1978 and on the patients in institutions in 1976, Bland (1982:2) looked at those persons affected by a major functional psychosis and examined their outcome data to determine how many of this group suffered from chronic disabling disorders⁽¹⁾. He found that a total of about 30 per cent of those with schizophrenia had an unfavourable to very unfavourable outcome; about 15 per cent of the manic depressive and recurrent depressive patients had an unfavourable to very unfavourable outcome; and only seven per cent of the non-recurrent depression patients had a similarly unfavourable outcome. Bland suggested, therefore, that approximately 0.35 per cent of the total population suffer from long-term psychological and social disabilities associated with reduced competence and coping skills attendant on these illnesses. Goldman (1981) using U.S. data has estimated that approximately one per cent of the population is chronically psychiatrically disabled enough to require living in some form of supportive setting. Consequently, the segment of the mentally ill population which requires continuing support upon discharge from hospital ranges between 0.35 per cent and 1.0 per cent of the general population.

2.2 GENERAL HOSPITAL PSYCHIATRIC UNITS

As the trend toward deinstitutionalization occurred, the Ontario government expanded its involvement in the provision of mental health services outside the psychiatric hospitals. In 1951, the Department of Health began to make funds available for the development of psychiatric services in general hospitals to provide more locally-based psychiatric care⁽²⁾. These psychiatric units were to

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(1) Bland calculated that the total prevalence for schizophrenia (male and female) is 8.55/1,000 and the total prevalence of affective psychoses (male and female) is 6.82/1,000.

(2) In 1948, the federal government introduced National Health Grants which spurred the extension of mental health services into general hospitals across Canada during the 1950s and 1960s.

serve patients on both an inpatient and outpatient basis. The size of each unit was limited to six per cent of the general hospital's total bed capacity (Ontario Ministry of Health Annual Report 1981-82:70). By 1953 there were four such units with a total of 123 beds.

Table II-2 shows the extent of the growth between 1960 and 1976[1].

Table II-2

Ontario Public Hospital Psychiatric Units: 1960 and 1976

	1960	1976
Patients on books (Dec. 31)	347	1,425
First admissions	3,041	16,670
Readmissions	1,396	13,332
Total admissions	4,784	31,427
Discharges	4,386	28,920
Deaths	19	32
Total separations	4,405	28,952
Bed capacity	431	1,946

Source: Health and Welfare Canada

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(1) During this same period, there was also a considerable increase in the use of general hospital psychiatric units across Canada for the treatment of the mentally ill. In 1960, over 19 million patient days were spent in Canadian mental hospitals and less than 0.25 million patient days in specialized psychiatric units of general hospitals (Richman and Harris, 1983:65). In 1976, there were 1.75 million patient days spent in general hospital psychiatric units, and 4.7 million patient days in mental hospitals (ibid.:70). Among Canadians spending less than one year in hospital during 1976-77, 2.9 million days were spent in general hospital psychiatric units and 3.8 million days in psychiatric hospitals (Richman et al, 1982:19).

The development of these general hospital psychiatric units certainly went some distance towards meeting the need for a better geographic distribution of psychiatric services across the province. However, the Committee on the Healing Arts, which examined the state of mental health care services in Ontario in the late 1960s, concluded that, while the province's inpatient facilities may have been, in aggregate, more than sufficient, there still existed both an imbalance to the detriment of outpatient facilities and a geographic maldistribution of inpatient facilities (Report of the Committee on the Healing Arts, 1970; Vol. 3, 143).

In addition, as the resident populations of the existing psychiatric hospitals declined and the number of general hospital psychiatric units increased, it became apparent that a streaming of the target population was taking place (Wilson, 1982:6). The psychiatric hospitals came to be seen as the preferred facility for the treatment of the mentally ill with a predominant diagnosis of psychoses, those who were chronically and severely disturbed. The general hospital psychiatric units, on the other hand, were admitting patients whose behaviour was non-disputive and who could be treated and discharged quickly.

2.3 THE COMMUNITY MENTAL HEALTH MOVEMENT

The beginning of the community mental health movement in Canada can be traced in part to the influential pioneer report, More for the Mind (1963), by the Canadian Mental Health Association(1). From its inception, the movement in

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(1) Other factors which contributed to the emergence of the community mental health movement in the 1960s include several government-sponsored reports which found the existing system fraught with problems; the increasing costs associated with inpatient care; the (continued on p.28)

Canada, as in the United States, has been associated with a number of diverse goals and activities. An important factor in the movement's early growth was the increasing evidence that long-term institutionalization is often not an appropriate response to mental illness(2). However, the movement, as it has matured, has become synonomous with several philosophical principles: a focus on total population rather than on the individual patient; comprehensive services for all age, social, and diagnostic categories; emphasis on the social environment and on prevention; preference for the community rather than the psychiatric hospital as the locus of treatment; a humanistic and patient rights-oriented ethic; and an interdisciplinary or team approach (Allodi and Kedward, 1977:222 as cited in Turner and Avison, 1983:282).

Advocates of the movement in the U.S. found a sympathetic political leader in the person of President J.F. Kennedy. In 1963, President Kennedy introduced major legislation which mandated the establishment of community mental health centres throughout the United States. The first of these centres came into operation in the late 1960s. A retrospective view of this phenomenon suggests that, at least in some parts of the United States, a comprehensive move from a mental hospital pattern of care to a community mental health centre pattern of care exposed chronic patients to the likelihood of neglect or to a level of care that fell short of being optimal (e.g., Bachrach, 1976 and 1980; Jolley, 1979; Leighton, 1982).

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passing of legislation which facilitated community-oriented treatment programs (e.g., the Canada Assistance Plan Agreement in 1966); and, of course, the development and use of psychotropic drugs (Turner and Avison, 1983:280)

(2) The recognition that public mental hospitals can sometimes do more harm than good has developed for some community mental health proponents into the belief that mental hospitals can never do any good and that even short-term hospitalization is of no therapeutic value.

Athough the community mental health centre model has not been widely adopted in Ontario, dissatisfaction with mental hospitals as the primary locus of care for the mentally ill has led to the establishment of volunteer advocacy organizations which share beliefs and objectives similar to those of the U.S. community mental health movement. The Canadian Mental Health Association had been operating in Ontario since it was founded in 1918 by Dr. C.M. Hincks. However, the Association's Ontario Division was organized in 1952 and it has become an important advocate for the development of community mental health care programs.

As the pattern of increased discharges from psychiatric hospitals continued in Ontario through the 1970s, it became clear that existing community care facilities (i.e., local general hospital psychiatric units and residential units such as Approved Homes and Homes for Special Care) were not meeting a number of important mental health care needs of both ex-psychiatric hospital patients and newly- emergent cases of mental illness. Mental health advocacy organizations became both more numerous and more vocal, and public pressure to develop a broader range of community mental health services increased.

In 1976, the Ministry of Health responded by establishing the Adult Community Mental Health Program (ACMHP) to fund programs whose sponsoring organizations were based in the community (including local general hospitals). With the development of the ACMHP, the Ministry of Health's concept of community mental health services was broadened to incorporate the provision of a range of local treatment (outpatient) and support services - for example, rehabilitation, housing and self-help programs - whose general purpose was to avoid institutionalization and to provide the least restrictive local setting for the treatment and care of the mentally ill individual.

The Ontario community mental health movement has also resulted in a definition of mental illness which encompasses a population larger than that traditionally served by the psychiatric service system. The range of illnesses treated has been extended to include less severe disorders which may require only short-term hospitalization or outpatient care. This trend was noted by the Committee on the Healing Arts more than ten years ago (Report of the Committee on the Healing Arts, Vol. 3, 1970:142) and there continue to be strong pressures to encompass an ever-broader range of states of mental distress and dissatisfaction within the mandate of the service system. Thus, mental health policy-makers have increasingly had to confront the difficult question, one made more difficult by current economic conditions, of how to delimit service delivery in terms of both the range of services provided and the target populations to be served by these services.

In conjunction with this development, there has been, not surprisingly, an expansion in the numbers and types of health professionals involved in the delivery of mental health care services. In the pre-1950 period, psychiatrists and nurses in the psychiatric hospitals, and, to a much lesser extent, general practitioners practising in the community, constituted the system's primary professional resources. Since then, psychologists, social workers, and occupational therapists have entered the field of mental health practice and the number and diversity of practitioners continues to increase. General practitioners now play a major role in the provision of mental health services. Unfortunately, there has been some disharmony amongst these professional groups over who should do what and what are the best means for achieving "mental health". This disharmony is often expressed in terms of the appropriateness of medical versus non-medical interventions, an issue which I believe to be artificial.

2.4 UNIVERSAL OF HEALTH INSURANCE

The Ontario Hospital Insurance Plan became effective in 1959. Every citizen of the province was thereby assured of hospital care when necessary regardless of income level. The Ontario Medical Services Insurance Plan was introduced in 1966 and modified several times in subsequent years(1). By the end of 1971, 99 per cent of the eligible residents of Ontario were covered by health insurance, of whom 1.3 million were receiving assistance in paying their premiums. As of April 1, 1972, the existing hospital and medical plans were combined into one comprehensive health insurance plan.

Prior to the introduction of universal health care insurance, only treatment services provided in and by the provincially-owned and operated psychiatric hospitals were available to those mentally ill persons with inadequate financial resources. The introduction of health care insurance (in conjunction with the increase in the number of general hospital psychiatric units) eliminated the economic barrier for the less affluent. Theoretically, health care insurance provided all Ontario citizens with a choice as to where they might seek treatment for mental illness. This created a situation substantially different from that in the United States where the public (state) mental hospitals remained the primary site for the treatment and care of the economically disadvantaged. However, as will be discussed later, the psychiatric hospital system in Ontario is still struggling to combat problems which are rooted in their pre-Ontario Health Insurance Plan history.

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(1) See Ontario Ministry of Health Annual Report 1981-82:82 for a description of the many changes which occurred in public health insurance during the late 1960s.

2.5 OTHER IMPORTANT DEVELOPMENTS

Other major developments are worth noting. The move towards a decentralized model for health planning began in 1965 when the Royal Commission on Health Services (Hall Commission Report, 1965) recommended regional and local health planning councils. Subsequently, regional and district health councils were recommended by the Ontario Council of Health in 1969 and 1970. The first formal District Health Council was established in the Ottawa-Carleton region in December 1973(1). The District Health Council model constituted the Ministry of Health's main response to the objective of decentralizing the process of health care planning across the province. In November 1978, the District Health Council Program was established to ensure a common approach among the Councils.

In April 1974, the responsibility for services to the developmentally handicapped (other than those provided by the disturbed mental retardation units in provincial psychiatric hospitals) was transferred to the Ministry of Community and Social Services to pave the way for the future delivery of services for the mentally retarded in the community. July 1977 saw the transfer of responsibility for the provision of mental health services for children from the Ministry of Health to the Ministry of Community and Social Services.

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(1) In some areas, notably in London, Hamilton, Toronto, Kingston, and Ottawa, the development of District Health Councils was preceded by the development of voluntary hospital councils (Dixon, 1981:11). These councils performed major planning functions connected with the allocation of federal funds for the development of medical centres.

A Mental Health Division within the Ministry of Health was established in 1966 with the responsibility for developing a provincial mental health program. During the next five years, there were indications that a new sense of role, direction, and purpose for the psychiatric hospitals and some momentum to achieve specific objectives were being forged. In 1972, however, the Ministry underwent a comprehensive reorganization and the Mental Health Division was dissolved. The psychiatric hospitals came under the new Direct Services Division within the Ministry. Some ten years later, in the fall of 1982, the Mental Health Division was reconstituted, bringing together the provincial psychiatric hospitals and adult community mental health services. Although general hospital psychiatric units continue to report to the Institutional Division, the Mental Health Division is responsible for policy development for all mental health services, including the psychiatric units.

From the first provincial psychiatric facility which opened its doors in 1850 and which had admitted 211 patients by 1853, mental health care in Ontario has grown into a large and complex component of the health care system. By almost any measure, mental health care is now a major enterprise which must provide treatment and care for those affected by a type of health disorder that is one of the most costly of all disease burdens, both in terms of human suffering and socio-economic impact.

SECTION III: CURRENT SITUATION:

A DESCRIPTION AND ANALYSIS

1.0 INTRODUCTION

Perhaps the single most difficult task in writing this Discussion Paper was the preparation of a comprehensive inventory of the ministries, facilities, agencies, organizations and other groups which provide mental health services. The intention in this section is to identify what is available and how it is used so as to provide a basis for identifying problems and issues. No claim is made to have captured all the subtleties of the current situation; a genuine effort has been made to describe it accurately and discuss it fairly.

Such an inventory has to be defined in the context of two major shifts. The first shift pertains to the increasingly important role played in mental health services by individuals, agencies and institutions outside the purview of the Ministry of Health. The second is related and pertains to the increasing importance played in Ministry of Health-funded mental health services by "non-institutional" modes of delivery.

To give the reader some indication of the scope and complexity of this first shift, it is useful to provide an overview of the levels of government and individual provincial government bodies which are involved (or may be involved) in the provision of mental health services (Chart AIII-1 in Appendix A offers a detailed description).

> **Ministry of Health: Direct Services** - These include mental health services provided directly by the MoH. The only services falling into this category are the 10 provincial psychiatric hospitals which absorb about a third of the MoH's total mental health expenditures.
>
> **Ministry of Health: Indirect** - This includes mental health services provided by various institutions, agencies and individuals funded by the MoH. Into this category fall:

- Special and community psychiatric hospitals.
- Public (general) hospital psychiatric units
- Public (general) hospital services

- Private psychiatric hospitals
- Community mental health organizations, agencies and associations
- Offical local health agencies
- Physicians

Other Provincial Bodies - This category includes those ministries and other bodies which are involved in providing social and other services directed towards special needs groups including the mentally ill. Of these, the largest single provider is the Ministry of Community and Social Services (MCSS). Others include the Ministries of Municipal Affairs and Housing, Education, Colleges and Universities, Correctional Services, Attorney General and the Civil Service Commission.

These provincial bodies fund, in whole or in part, a host of programs which relate directly or indirectly to mental health. For example, MCSS funds most children's mental health services and also General Welfare Assistance through municipal social service departments; Education funds local school boards which provide Early Identification Programs and assessment and counselling services.

In addition, there are some provincial bodies, such as the Ministry of Tourism and Recreation, Recreation Division, which have a potentially important role to play in mental health services, but are still in the process of clarifying and defining that role.

Municipal/Regional Governments - These governments provide social services including income assistance and housing supplements, and also influence the supply of non-institutional accommodation through their zoning bylaws.

Federal - Health and Welfare Canada is responsible for the health of native peoples and veterans, provides grants to community groups, funds extra-mural research conferences, task forces and mental health publications. The Department of

Employment and Immigration offers a number of employment counselling programs, many of which have services specifically addressed to the needs of the disadvantaged and the disabled, including the psychiatrically disabled.

Non-formal - This category includes psychologists, social workers, lay counsellors and a host of others who provide mental health counselling on a private fee-for-service basis. Also included are privately supported agencies and organizations who provide services used by the mentally ill.

This list gives some idea of the scope and complexity of the mental health field. It suggests that it is misleading to speak of a single or unified 'mental health care delivery system'. Instead, there are a host of providers and systems both within and outside the MoH. Some crude distinctions are possible: the Ministry of Health is responsible for providing mental health services for adults, including the elderly; the Ministry of Community and Social Services is responsible for children's services (although the MoH also provides some children's mental health services, and MCSS funds various types of mental health-related services to all age groups).

With such an array of diverse resources directed to mental health care, it is not unlikely that on any given day there may be almost as many people receiving mental services of one kind or another from an agency or individual outside the purview of the MoH as there are receiving services from an agency or individual within the purview of the MoH. The list also provides some indication of the limited ability of the Ministry of Health on its own to bring about changes in the mental health field.

For example, Table III-1 describes the proportion of Ministry of Health expenditures in relation to total expenditures on mental health in Ontario over the past decade. Total expenditures include those made by federal departments, MoH, MCSS, associations and individual consumers. These figures have to be treated with caution because of different data assumptions, but they do suggest that the proportion of total mental health funding provided by the MoH has dropped from about 97 per cent in 1970/71 to approximately 57 per cent in 1981/82. This drop is due in large measure to the shift of the burden of responsibility for mental retardation and children's services from MoH to MCSS during the seventies.

Table III-1

Estimated Proportion of Ministry of Health Contribution to Total Mental Health Expenditures in Ontario: 1970/71 - 1980/81

($000,000)

	1970/71	1978/79	1980/81	1981/82***
Total Expenditures	281.6*	741.9	926.6	997.6
Ministry of Health	272.7	429.6**	518.8	570.7
MoH Percentage	97%	58%	56%	57%

* Includes $8.8 million for federal hospitals and $1.3 million for MCSS payments for the mentally retarded.

** Reflects the shift of mental retardation services and most children's services to MCSS.

*** Preliminary

Source: Ministry of Health and Ministry of Treasury and Economics, Central Statistical Services, 1983.

The proportion of mental health expenditures by the Ministry of Health would likely be lower if we were able to include payments to private psychologists, social workers and lay counsellors who provide mental health services on a fee-for-service basis outside any Ministry or agency structure and about whom no data are available.

The second shift is related to the first and pertains to the increasing importance played in Ministry of Health mental health services by "non-institutional" modes of delivery. One expert remarked that 40 years ago perhaps 0.1 per cent of the Ontario population received psychiatric services and about 98 per cent of those services were delivered on a hospital inpatient basis; whereas today perhaps 1.0 per cent of the population receives some form of psychiatric services and about 98 per cent of those services are on a non-inpatient basis. I have not been able to confirm this estimate. Nonetheless, there has been a substantial shift in service delivery and resources to the non-inpatient component, a shift which has not received adequate recognition. It is discussed in detail in the following pages.

1.1 SUMMARY ANALYSIS OF MINISTRY OF HEALTH MENTAL HEALTH ACTIVITIES

The range of mental health services provided or funded by the Ministry of Health includes:

- Physicians: general practitioners, psychiatrists and other medical specialists.
- Community Mental Health Services (Adult).
- Alcohol and Drug Abuse Grants in Aid (phased out since 1979 and replaced by grants through other funding programs).
- Health Resources Development Plan: a program for manpower grants.
- Detoxification Centres.
- Provincial Psychiatric Hospitals.
- Psychiatric Units in Public (General) Hospitals.
- Grants to Associations.
- Clinical, Applied and Other Health Research.
- Grants to Official Local Health Agencies.
- Homes for Special Care.

MoH expenditures on these mental health services have increased substantially over the past decade from $272.7 million ($35.42 per capita) in 1971/72 to $570.7 million ($66.17 per capita) in 1981/82.

Over the past years, mental health expenditures have decreased from about 10.8 per cent of total MoH expenditures in 1978/79 to 9.8 per cent in 1981/82. This kind of observation assumes, however, that there is a "mental health budget" within the Ministry and that funds can be shifted from one service component to another within this budget. This is not the case. MoH expenditures allocated to mental health services come from a number of different programs (Table III-3), not all of which are within the Mental Health Division. For example, about 20 per cent of "mental health expenditures" fall into the category of Payments to Physicians and another 22 per cent are payments for general hospital psychiatric units (GHPUs). In other words, at least 42 per cent of expenditures on services for mental health lie outside the control of the Mental Health Division (Table III-3).

Another point to keep in mind when considering these figures is that payments to physicians for mental health services are determined by a combination of market demand and the influence of the OHIP tariff on the type of service, and not by MoH policies. The increase in payments to physicians is made up of payments to general practitioners, psychiatrists and other physicians as a result of both an increase in the number of OHIP services provided and an increase in the OHIP fee to psychiatrists to bring them more into line with other medical specialists. Although these payments have increased substantially over the past few years, they are not part of any planned program or budgetary allocation to mental health services. In this respect, the reported total increases in mental health expenditures can be somewhat misleading.

A more detailed examination of these figures (Table III-2) suggests that the MoH is making efforts to shift dollars from inpatient hospital services to outpatient services and to non-treatment components of mental health services. Expenditures on provincial psychiatric hospitals and general hospital psychiatric units continue to constitute the greatest proportion of MoH mental health expenditures, but that proportion has declined over the past few years, as Table III-2 indicates, from 61 per cent to 56 per cent.(1)

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(1) Table III-2 does not include expenditures for psychiatric care provided in general hospital medical and surgical beds. MoH staff estimate that these expenditures were approximately $11.6 million in 1979/80 and $14.2 in 1981/82.

Table III-2

Proportionate Allocation of Ministry of Health Expenditures on Mental Health Services: 1978/79 - 1981/82

	1978/79 %	1981/82* %
Psychiatric Hospitals	36.9	33.9
General Hospital Psychiatric Units	24.3	22.0
Physicians	14.2	19.6
Homes for Special Care	13.6	13.1
Grants to Community Mental Health	6.1	5.4
Grants to Associations	2.7	3.9
Other**	2.2	2.1
TOTAL	100	100

* Preliminary

** The "Other" category includes grants to official local health agencies, clinical applied and other health research, detoxification centres, health resources development plan and alcohol and drug abuse grants in aid which have been phased out since 1979.

Source: MoH, Data Development and Evaluation Branch

Table III-3

SUMMARY OF EXPENDITURES BY MINISTRY OF HEALTH ON MENTAL HEALTH SERVICES - 1978/79 and 1981/82

	1978 - 1979			1981 - 1982*			
	Expenditure $	%	Per Capita $	Expenditure $	%	Per Capita $	% Change
Payments to Physicians	60,921,656	14.2	7.21	112,067,695	19.6	12.99	84
Grants to Community Mental Health	26,039,184	6.1	3.08	30,730,146	5.4	3.56	18
Alcoholism and Drug Abuse Grants in Aid	443,806	.1	.05	--	--	phased out after 1979	--
Health Resources Development Plan	139,815	.0	.00	140,360	.0	.0	--
Detoxification Centres	2,599,584	.6	.31	4,045,739	.7	.47	56
Psychiatric Hospitals	158,369,951	36.9	18.76	193,562,724	33.9	22.44	22
Psychiatric Units in Public Hospitals	104,538,349	24.3	12.38	125,427,320	22.0	14.54	20
Grants to Associations	11,466,155	2.7	1.36	22,258,068	3.9	2.58	94
Clinical Applied and Other Health Research	3,182,390	.7	.38	3,846,300	.7	.47	21
Grants to Official Local Health Agencies	3,615,112	.8	.43	3,988,913	.7	.47	10
Homes for Special Care	58,326,841	13.6	6.91	74,608,187	13.1	8.65	29
TOTAL	429,642,843	100.0	50.87	570,675,452	100.0	66.17	33

* Preliminary

Source: MoH, Data Development and Evaluation

The significance of this decrease becomes apparent when one looks at per capita expenditures (Table III-3) which illustrate clearly that the lowest rate of growth in expenditures has been for provincial psychiatric hospitals and general hospital psychiatric units. Essentially, the declining proportion of expenditures directed towards hospitals has freed some funds for non-inpatient services.(1)

One of the major themes of this report is the uneven distribution of mental health services across the province. Tables III-4 and III-5 illustrate this.

Table III-4

Distribution of Mental Health Funding by Region: 1978/79 -1980/81

Regions	Per Capita Expenditures 1978/79	Per Capita Expenditures 1980/81
South West	$ 59.85	$ 69.75
Central West	34.77	40.81
Central East	52.20	62.03
East	62.62	77.15
North East	41.97	49.83
North West	60.68	71.56

Source:Ministry of Health, Data Development and Evaluation Branch, November 1982.

Table III-5 provides the most recent figures available on the current distribution of mental health expenditures across the six health planning regions of the province.(2) The lowest per capita expenditure is in Central West (Hamilton and area) and the highest is in the Eastern Region (Ottawa and area). Table III-5 also shows the distribution of funding by service category. What is striking is the variability in expenditures from region to region (e.g., Homes for Special Care, Grants to Community Mental Health).

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(1) Most of the Community Mental Health Services funds for treatment programs are provided to hospital outpatient or community clinics, both of which operate under their own separate committees.

(2) See Section 7.4 for a discussion of the health planning regions.

Table III-5

SUMMARY OF PER CAPITA EXPENDITURES BY MINISTRY OF HEALTH ON MENTAL HEALTH SERVICES BY REGION: 1980-1981

Program	Provincial $	South West $	Central West $	Central East $	East $	North East $	North West $
Payments to Physicians	10.09	6.04	7.41	13.53	12.87	2.84	2.38
Grants to Community Mental Health	3.78	1.44	6.30	1.99	7.71	5.67	1.41
Alcoholism and Drug Abuse Grants in Aid	.02	.01	.02	.02	.04	.00	.01
Health Resources Development Plan	.03	.03	—	.03	—	—	—
Detoxification Centres	.41	.38	.42	.32	.28	.67	1.93
Psychiatric Hospitals	21.72	31.09	11.29	18.54	30.17	21.59	51.94
Psychiatric Units in Public Hospitals	13.50	15.16	11.63	14.69	14.66	7.92	7.63
Grants to Associations	2.31	—	—	5.51	—	—	—
Clinical Applied and Other Health Research	.42	.42	.42	.42	.42	.42	.42
Grants to Official Local Health Agencies	.44	.52	.30	.46	.25	1.06	.37
Homes for Special Care	7.82	14.70	3.02	6.52	10.75	9.66	5.47
TOTAL	60.54	69.79	40.81	62.03	77.15	49.83	71.56

Source: Ministry of Health, Data Development and Evaluation Branch, November 1982.

There are a number of reasons, discussed throughout this Discussion Paper, for the disparities in per capita expenditures for various services across the six regions. Some of these reasons are historical: for example, where the PPHs are located. Other reasons have to do with the relative scarcity of agencies and professionals in a given region which can receive funds to provide the services required in that region, and with current economic conditions which limit the funds available to support new organizations in various regions to provide services needed there.

It is also possible that the demand for certain kinds of services in some regions is lower than in other regions. For example, if we look at the Payments to Physicians category, we see that the use of physicians services is highest in Central East, which includes the Metropolitan Toronto area, and in the Eastern region, which includes Ottawa, and lowest in the two northern regions. This difference may be partly a function of the relative scarcity of physicians in the north to whom people can go for services.

Notwithstanding the possible reasons for these disparities, it seems evident that some regions of the province are better provided with mental health services than are other regions. This is reinforced by an examination of the distribution of Community Mental Health Services programs (Charts III-2.1, III-2.2 and III-2.3).

Chart III-2.1 summarizes the current distribution of programs funded by Community Mental Health Services (CMHS) across the province. It distinguishes between those programs which receive on-going funding and those which are still in the two-year period of development. Charts III-2.2 and III-2.3 indicate the substantial growth in programs funded by Community Mental Health Services from fiscal year 1982/83 to 1983/84 and an improved distribution of these programs across the various regions of the province. Nonetheless, there are still a number of programs which are not provided in a number of regions, particularly Self-Help and Prevention.

Chart III-2.1

Regional Distribution of Community Mental Health Services Programs as of September 1983*

	# of Developmental Programs**	# of Ongoing Programs***
South West	18	16
Central West	22	20
Central East	46	54
East	10	19
North East	11	6
North West	7	4
TOTAL	114	119

* Does not include approximately 20 alcohol and drug programs.
** New program.
*** Program approved for ongoing funding.

Source: Mental Health Division, MoH.

Although the situation has improved considerably over the past few years, where a person lives in Ontario still has a great deal to do with whether various types of mental health services are available and how available they are.(1)

1.2 AN ANALYTIC FRAMEWORK

With such a diverse and fragmented assortment of mental health services and resources in place, the first task is to develop a comprehensible framework within which to describe them. The framework is necessary not only for descriptive purposes but also for analyzing the adequacy of the existing array of services and for determining if and where changes should be made.

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(1) Until fiscal year 1983/84 Alcohol and Drug Treatment services and Detoxification Units were administered under a different program. If one excludes these two types of programs for purposes of comparison, the figures show an increase in CMHS-funded programs from 156 in 1982/83 to 204 in 1983/84.

Chart III-2.2

Community Mental Health Services Programs: 1982/83*

Region	Co-ord Services	Housing Programs	Prevention	Psycho-geriatric Programs	Rehab. Programs	Self-help	Treatment Programs	Volunteer Programs	Total**
1. South West	3	6	1	1	10	--	6	1	28
2. Central West	--	1	1	--	5	--	8	1	16
3. Central East	5	15	2	4	24	1	21	3	75
4. East	1	3	--	3	5	--	4	--	16
5. North East	--	--	--	--	--	--	6	3	9
6. North West	1	1	--	--	1	--	5	--	8
TOTAL	10	26	4	8	45	1	50	8	152

* As of November 1982.

** At this time, alcohol and drug abuse programs and detoxification units were administered under a different program.

Source: Mental Health Division, MoH.

Chart III 2.3

COMMUNITY MENTAL HEALTH SERVICES PROGRAMS: 1983/84*

Region	Co-ord. Services	Housing Programs	Prevention	Psycho-geriatric Programs	Rehab. Programs	Self-help	Treatment Programs	Volunteer Programs	Alcohol & & Drug Treatment Programs	Detoxification Units	Total
1. South West	3	5	1	1	13	--	8	--	3	2	36
2. Central West	-	9	3	1	10		13	1	5	3	45
3. Central East	5	25	2	4	28	1	23	5	7	5	105
4. East	2	6	-	3	5		4	-	9	2	31
5. North East		1			2		11	1	4	2	21
6. North West	2	1			2	--	5	--	1	2	13
TOTAL	12	47	6	9	60	1	64	7	29	16	251**

* As of September 1983.

** This table includes two programs in the North East region which are not included in Chart III-2.2.

Source: Mental Health Division, MoH.

A number of mental health service system models have been developed, including the Balanced Service System Model used in Georgia, western Pennsylvania and elsewhere, the California model, the Denver model and the British Columbia model.(2) Each of these has particular advantages. Some of the questions which need to be examined when considering a framework include (Cohen, 1982):

- Do we base the framework on the types of organizations providing services in the mental health field, on the types of needs, on the types of programs and services, or on some other set of categories?
- What bases do we use for defining what falls within the constellation of mental health and how do we avoid being so comprehensive that definitions lose effective operational meaning?
- What is the best way to organize this information so as to accommodate the diverse information needs and capabilities of the various providers in the public, private profit and not-for-profit, and volunteer sectors?

The functional approach seems to be the most useful way to proceed, and is perhaps the most familiar in Ontario. Cohen (1982) has set out a conceptual and definitional framework using the functional approach (Chart III-3). Etobicoke Mental Health Services Agency (Tang, 1980) has developed a somewhat different framework which is also based on the functional approach (Chart III-4). Both these models deal primarily with the program and service functions (see also Appendix B for a description of these models). I propose, at least for the purposes of discussion, a broader functional approach:

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(2) See Appendix B for a description of these models prepared by Cohen, 1982.

Chart III-3

MENTAL HEALTH PROGRAMS/SERVICES CLASSIFICATION SYSTEM

MAJOR PROGRAM AREAS	SERVICES	ACTIVITIES
Case Identification		
Assessment	Evaluations	Psychological evaluations, family/social evaluations Psychiatric evaluations Addiction evaluations
	Consultations Diagnosis	
Referral	Inter-agency Co-operation	
	Case Management	
Treatment	Crisis Responses	Emergency services Crisis services Crisis intervention
	Therapy	Psychological therapy, social therapy Physical therapy
Rehabilitation	Vocational/Educational Services	Pre-vocational services, vocational assessment training/retraining programs, sheltered workshops, job search training
	Accommodation	Co-operative housing, half way house, homes for special care beds, in-patient beds in general or psychiatric hospital
	Social/Recreation/Leisure Services	
	Interpersonal/Personal Support	Life skills, counselling
	Familial Support	Professional back-up, counselling activities, vacation relief
Maintenance	Vocational/Educational Services	Transitional employment opportunities and sheltered workshops, job placement services
	Accommodation	Co-operative housing, halfway house, rooming house subsidized houses, homes for special care beds, in-patient beds (hospitals)
	Social/Recreational/Leisure Services	
	Interpersonal/Personal Support	Life skills, counselling, follow-up services

Source: Cohen, 1982.

Chart III-4

THE SPECTRUM OF MENTAL HEALTH SERVICES FOR ADULTS

	Prevention			Treatment	Rehabilitation
Program Examples	Community Education	Early Intervention	Crisis Intervention		
	Agency Consultation	Distress Counselling	Psychiatric Emergency Services	Assessment	Day Care
				Referrals	Home Support Programs
	Community Organization	Addiction Counselling	Emergency Home-visiting Programs	Short-term Treatment	Vocational Training
				Chronic Long-term Treatment	Sheltered Workshops
					Life Skills Training
					Socialization and Recreation
					Alternative Housing Program

Source: Tang, 1980.

1. Mental Health Programs
    - Case identification
    - Assessment
    - Referral
    - Treatment
    - Rehabilitation and Maintenance
    - Prevention
2. Volunteers
3. Planning and Co-ordination
4. Research
5. Human Resources

This categorization has the advantage of following an individual through the various levels and sectors of mental health services, starting with case identification. No attempt has been made to discuss two other categories, management/administration and costs, because they lie outside the terms of reference for this study.

2.0 GATEKEEPERS AND PATHWAYS

These terms are used as a collective for those activities usually described as case identification, assessment and referral.(1)

Case identification refers to the detection and identification of individuals who require some assistance with respect to their mental well-being. Case identification does not include treatment. Persons may come forward voluntarily seeking help, in which instance they are self-identifying; others are unwilling, do not recognize the need for assistance or are unable to seek assistance. In these cases, the major resources for case identification include: the family, the general or family practitioner, other medical specialists, the local public health unit, municipal social service departments, the hospitals, the police and the courts.

Assessment involves evaluation, consultation, and diagnosis directed towards identifying the type, nature and extent of an individual's problems. These activities usually take place as a prerequisite to the individual's entry into treatment or other services. Referral involves matching the needs of the individual with the most appropriate service, and placing him or her with that service.

Case identification, assessment and referral, particularly the first two activities, are frequently carried out by the same individual or agency. These individuals and agencies constitute the front line of mental health services in Ontario and are, in effect, the 'Gatekeepers' of mental health. They are the single most important group in terms of what happens to the patient or client entering the mental health service field.

There are two types of gatekeepers: those in the non-formal mental health sector, about whom there is little information, and those in the formal sector. This discussion focusses on those in the formal sector.

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(1) The definition of these three terms are derived to a large extent from Cohen, 1982.

Most people who seek help for a mental disorder never see a psychiatrist or the inside of a mental health clinic or psychiatric facility. The great majority of people who receive treatment services from the formal mental health sector receive them from a family or general practitioner.

Chart III-5 sets out the kind of filtering process which typically takes place, and summarizes a study based on the experience in Britain and the United States (Goldberg and Huxley, 1980). This study suggests that the actual psychiatric morbidity rate is 250 persons per 1,000 population and that there are five levels of mental health filters. Of these 250 persons, 230 go first to the local family or general practitioner. The general practitioner makes a psychiatric diagnosis in 140 of these cases; he treats 123 of the cases himself, and refers the remaining 17 (seven per cent) of the cases to out-patient or private psychiatric services. Of these 17 referrals, six (two per cent) are admitted to a psychiatric facility. These figures provide a useful perspective on the size of the demand for mental health services and on the filtering of that demand through the various levels of increasingly specialized treatment services.

These figures are consistent with other studies; for example, Cleghorn et al (1982) estimated that in any given year at least 15 per cent of the population suffer from a diagnosable mental disorder. A detailed survey of medical services users in Saskatchewan found that a yearly average of eight per cent of the adult population in that province received some type of psychiatric treatment from 1969 to 1974 (Schmitz et al, 1979:14).

The Saskatchewan figures may be somewhat different than those in Ontario because the Saskatchewan figures reflect the closing of the two major mental hospitals and Saskatchewan is also primarily a rural society. Nonetheless, there is no doubt that in Ontario the great bulk of formal

Chart III-3

A TYPOLOGY OF PSYCHIATRIC PATHWAYS

	The Community	Primary Medical Care		Specialist Psychiatric Services	
	Level 1	Level 2	Level 3	Level 4	Level 5
	Morbidity in random community samples	Total psychiatric morbidity, primary care	Conspicuous psychiatric morbidity	Total psychiatric patients	Psychiatric inpatients only
One-year period prevalence, median estimates	250/1,000	230/1,000	140/1,000	17/1,000	6(per 1,000 at risk per year)

	first filter	second filter	third filter	fourth filter
Characteristics of the four filters	Illness behaviour	Detection of disorder	Referral to psychiatrists	Admission to psychiatric beds
Key individual	The patient	Primary care physician	Primary care physician	Psychiatrist
Factors operating on key individual	Severity and type of symptoms Psycho-social stress Learned patterns of illness behaviour	Interview techniques Personality factors Training and attitudes	Confidence in own ability to manage Availability and quality of psychiatric services Attitudes towards psychiatrists	Availability of beds Availability of adequate community psychiatric services
Other factors	Attitudes of relatives Availability of medical services Ability to pay for treatment	Presenting symptom pattern Socio-demographic characteristics of patient	Symptom pattern of patient Attitudes of patient and family	Symptom pattern of patient, risk to self or others Delay in social worker arriving

Source: Goldberg and Huxley, 1980: 11.

mental health assessment and treatment services are provided by the general or family practitioner.(1)

Several conclusions can be drawn from these findings. First and foremost, general practitioners are by far the largest providers of mental health care identification, assessment, referral and treatment services. Without the local doctor, existing formal mental health services in this province would be swamped. The array of designated mental health service deals with only a relatively small proportion of the client population. I doubt that most of the other mental health professionals, including psychiatrists, are aware that they come in contact with only a fraction of those persons who seek and require mental health services.

A second conclusion is that the actual levels of utilization of designated mental health services do not reflect the actual levels of need for such services and, in fact, may underrepresent that need by as much as 44 per cent (110/250 cases).

The Goldberg and Huxley figures noted above suggest there is a "hidden" psychiatric morbidity rate of about 110 persons per 1,000: that is, the actual rate is 250/1,000; 230 go to the doctor and the doctor detects only 140 of these cases, leaving 20 who do not go to a doctor and 90 whose mental illness escapes diagnosis.

There are several possible reasons for the doctor's failure to diagnose all the psychiatric cases which come before him or her. One reason is that the psychological symptoms may not be obvious at the time of the patient's visit, or the patient may, indeed, hide them. Another reason may be the doctor's lack of training or skill in the identification of mental illness symptoms. A third reason may be professional bias; some general practitioners prefer not to deal with mental disorders and hence tend not to look for symptoms which would indicate the presence of such disorders.

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(1) OHIP fee-for-service data for the years 1977/78 -1981/82 show that psychotherapy services provided by general practitioners increased by 36 per cent and payments by 148 per cent during that period, while those for psychiatrists increased only by 21 per cent and 104 per cent respectively. This appears to be congruent with the U.S. experience where it is calculated that, of the 15 per cent of Americans estimated to have mental disorders, only 20 per cent are being treated by mental health professionals and 60 per cent are being treated by general physicians. ("Need seen for GPs Education in Mental Health Care", June 3, 1983, American Psychiatric Association Psychiatric News, 17).

Some patients who seek mental health services from general practitioners might be better served by other services; both the patient and the general practitioner need to be better informed about appropriate alternatives, including non-medical treatment.

The other gatekeepers, although they deal with fewer persons, also play an important role. The official local health agencies - public health units - are important gatekeepers, particularly among more isolated individuals in the community who do not have a doctor. Public health units are at the front line of community mental health services, particularly with respect to the identification of the need for such services.

Activities which may be carried out by health units to individuals, families and groups include (Ontario Ministry of Health, 1977):

1. Mental Health Assessment
2. Mental Health Referral
3. Supervision of Treatment Programs
4. Counselling
5. Crisis Intervention
6. Case Conference Consultation
7. Promotion of Mental Health
8. Assessment of Community Mental Health Needs
9. Planning and/or Co-ordination of Community Mental Health Programs

Public health nurses can be found in schools, hospitals, community centres, nurseries, clinics and physician practice attachments. As well as acting as gatekeepers, public health nurses are strategically placed to deliver mental health services on a continuum of primary, secondary and tertiary prevention through crisis intervention to maintenance and rehabilitation programs. Unfortunately, information with respect to the mental health activities of the

Unfortunately, information with respect to the mental health activities of the various health units is uneven. Forty of the 43 official local health agencies are on the Community Health Activity Resources Information System (CHARIS). For the purposes of CHARIS, the mental health coding category is used for any preventive, therapeutic or rehabilitative sessions for those individuals with any type of mental and/or emotional disorder. The CHARIS system does not capture any information on the type of activity involved in these mental health contacts. The definition of a mental health contact can vary, and likely does, from health unit to health unit.

The data suggest (Table III-6), however, that only a small proportion of the work of public health nurses involves mental health. The question, then, is what role should the public health units, particularly public health nurses, be playing. Do they identify and screen? Do they treat? Do they act as the patient's guide through the mental health system?

The data in Table III-6, which summarizes CHARIS records from April 1979 to March 1982, indicates that there has been a drop in the number of mental health contacts as a proportion of total contacts made by the various local health units: a drop from 7.5 per cent to 5.5 per cent. The reliability of these figures has to be assessed in the context of the considerable reported variations in the incidence of mental health contacts among the various health units which range from 2.5 per cent in the East Region to 9.7 per cent in the North East, but only 3.5 per cent in the North West. A MoH survey conducted a few years ago indicated that approximately 8.4 per cent of public health nurse contacts were with individuals with mental health problems (Ontario Ministry of Health, 1977); however, the Halton Regional Health Department informed us that for the calendar year 1982, 19.6 per cent of its total contacts were in the area of "mental illness".

These differences suggest there are discrepancies in the methods used by the various local health units to identify, or to categorize the mental health needs of their clients. Clearly, it would be useful if all local health units participated in CHARIS and if standard definitions were used with respect to "mental health contact" and the types of activities involved in this contact.

Table III-6

MENTAL HEALTH CONTACTS - OFFICIAL LOCAL HEALTH AGENCIES

	Total Individual Contacts	% Mental Health Contacts	Total Clinics	% Mental Health Clinics
		April 1979 - March 1980		
South West	109047	8.1%	11402	0.9%
Central West	230168	5.4	9194	1.7
Central East	556435	10.1	37632	2.9
East	229569	3.3	20215	0.1
North East	71629	7.7	5875	3.0
North West	108412	6.9	10170	0.2
	1305260	7.5%	94488	1.7%
		April 1980 - March 1981		
South West	114276	6.79%	19490	0.36%
Central West	213842	4.44	12369	1.09
Central East	525151	7.73	59751	1.9
East	206723	2.94	19205	0.16
North East	69824	9.9	10725	2.7
North West	111682	3.9	14452	0.17
	1241498	6.05%	135992	1.2%
		April 1981 - March 1982		
South West	157292	5.6%	33600	0.33%
Central West	220405	4.6	12654	1.34
Central East	562497	7.1	69893	1.88
East	219609	2.5	23805	0.18
North East	71674	9.7	13361	2.17
North West	112836	3.5	16282	0.09
	1344313	5.6%	169595	1.15%

Source: Ontario MoH, Public Health Branch.

The remainder of case identifications and assessments are carried out by hospital emergency and intake staff, corporate medical staff, medical specialists, psychiatrists, psychologists, social workers, family counselling divisions of municipal social service departments and vocational rehabilitation services of MCSS. The nature of these assessments varies considerably.

The importance of the psychological assessment services of local school boards should be noted. Each school board may have on staff, or have access to, a psychologist. Each school board is, however, required to provide an Early Identification Program for all elementary school students. The purpose of this program is to identify those students with learning disabilities or other mental problems. The effect of this program is to identify many of those students in the incipient or early stages of mental illness. Consequently, the Early Identification Program can be valuable, given the human and financial costs involved if a mental illness is not identified until it has reached a mature stage. It appears, however, that this Program is not well developed and that, once a child is identified as requiring help, it is often difficult to obtain the specialized service.

In general, persons who do not have a family doctor, and there are increasing numbers of them, are not likely to be identified unless they come to the attention of a social service agency, local health unit, some similar agency or the police. The situation is unsatisfactory, but solutions are not easy to come by. People who do not wish to come forward cannot be compelled to do so except by the police and the courts.

Of all the gatekeeper activities, perhaps the most in need of immediate improvement is that of psychiatric emergency or crisis services. Crisis services are not well distributed across the province, and those which do exist often lack appropriate facilities and staff. The first contact an individual has with mental health services is often when he or she suffers a psychiatric crisis involving disturbing behaviour and immediate action is required. The nature of these crises sometimes involves the need to control physical behaviour. In all crises, the priority is to stabilize the mental disorder so that a full psychiatric assessment can be carried out. The appropriateness of the hospital's response to these crises varies depending upon the facilities, the staff and the attitudes of the personnel available to the emergency department at the particular time.

It is the policy of provincial psychiatric hospitals (PPHs) to have a psychiatrist or physician on call or, less commonly, on site 24-hours a day, seven days a week. They are, therefore, in a position to admit crisis patients whenever they appear. In defined cases, however, a patient will not be admitted but referred elsewhere. These cases include a patient whose physical condition is such that in the opinion of the admitting physician adequate medical care cannot be given; a patient who requires a medium secure setting and the hospital lacks one; and a patient who is intoxicated. Also, the lower age limit for admission is recognized to be 16 years except in "very special circumstances" where no other resources are available (MoH, Mental Health Division).

Provincial psychiatric hospitals can play only a limited role in crisis services because there are just ten of them in the province. The major local resource for crisis services is the general hospital, 75 per cent of which do not have a psychiatric unit. While some general hospital psychiatric units (GHPUs) do provide crisis services 24 hours a day, the type of patient accepted for assessment is often dictated by the patient's behaviour because of the lack of appropriately trained hospital staff, particularly during the late evening and early morning hours, and the lack of safely-keep facilities. Consequently, many GHPUs will simply refer the patient to a PPH or another psychiatric facility. There are some examples of effective crisis services in general hospital psychiatric units: St. Joseph's in Hamilton and Owen Sound General and Marine; the Clarke Institute in Toronto also provides a comprehensive crisis service staffed by a multidisciplinary team.

General practitioners will sometimes provide crisis service - although seldom at night - and often arrange to meet the patient at a hospital. However, not all general practitioners are affiliated with a hospital. Those who are not must arrange for the patient to be sent to Emergency and then find a specialist affiliated with that hospital who will admit and assess the patient.

There are telephone and walk-in distress centres services provided by a number of organizations across the province. They offer support and referral, but they are often not formally associated with a facility which can provide psychiatric back-up.

The police often find themselves involved in crisis situations involving mentally ill persons. By law, they cannot take a mentally disordered person into custody unless they have reason to believe that the person has committed an offence. Once they have taken a mentally disturbed person into custody, they cannot release him except into the custody of a doctor. Consequently, they can spend hours sitting in a hospital waiting for a doctor to become available who is willing and able to take responsibility for the patient, or travelling around the countryside - a major problem in the north - looking for a hospital where such a doctor might be: a difficult situation for an emotionally confused, excited and occasionally dangerous patient, and for the police officer, and one that is wasteful of everyone's time and the taxpayer's money (The Ontario Council of Health, 1979a:120).

There are many gatekeepers and pathways to mental health services. Whom an individual first seeks out or comes in contact with as a result of a mental illness can have a bearing on the detection and diagnosis of the problem, the treatment prescribed, and the location of the treatment: at home, in a professional's office, in an outpatient setting or clinic or in any number of different types of psychiatric facilities. It is my sense that, where assessments are carried out by professionals or others in the private sector, the diagnosis is more likely to be one which allows the patient or client to remain in the community and receive treatment or care on a private or outpatient basis.

3.0 TREATMENT

3.1 INTRODUCTION

Once the individual has been identified as being in need of help, there are a number of treatment modes available. The selection of a specific treatment mode is affected by a number of factors, one of which is the nature of the mental disorder or illness.

As noted earlier, there are two spheres of mental health services which provide treatment. The 'formal' sphere includes those services provided or funded by the Ministry of Health, plus some of the services provided or funded by the Ministry of Community and Social Services, Education, Colleges and Universities. Service providers in this sphere include private general and psychiatric practitioners, local public health units, hospitals, children's mental health centres, various family and social service agencies, school guidance departments and other public and quasi-public bodies.

The second, 'non-formal', sphere includes psychologists, social workers and lay therapists of various kinds and qualifications who work outside a recognized agency or reporting system. It is not possible to determine how many people there are across the province who fall into this category or the type and quality of the treatment they provide to their clients. The situation is further complicated because a number of psychologists and social workers work within the 'formal' mental health sphere during the day, or on a part-time basis, and work in the 'non-formal' sphere the rest of the time. Those working in the non-formal sphere are discussed in Section 9, Human Resources. The remainder of this discussion deals solely with the formal mental health sphere.

The major provider of mental health treatment services in the formal sphere is the general or family practitioner who accounts for an estimated 80 per cent or more of all mental health cases which fall within the purview of the Ministry of Health (Goldberg and Huxley, 1980; Schmitz et al, 1979). In other words, general practitioners manage five or more patients for every case that reaches the public or private psychiatric sector. The

Saskatchewan data (Schmitz et al, 1979) indicate that 75 per cent of persons receiving a psychiatric diagnosis in one year were seen only by their general practitioner; the Saskatchewan data also suggest that general practitioners treated more patients in every diagnostic category than did any other type of medical practitioner (ibid.:5). About 47 per cent of those treated by the general practitioner appeared to have relatively minor problems which required only short-term outpatient treatment (ibid.:19).

If about 47 per cent of the mental health services provided by general practitioners involve relatively minor problems, the question arises as to whether the general practitioner is the most appropriate professional to deal with these problems. For one thing, it has been suggested that general practitioners tend to feel uncomfortable generally with patients who have psychiatric symptoms (e.g., Werkman et al, 1976). They also rank marital problems as the most common "psychiatric" problem and the second most difficult to treat (ibid.). Although referral to non-physician therapy/counselling services might be more cost-effective for the public purse as well as more appropriate for the patient, there are financial and other disincentives for both the patient and his or her general practitioner which reduce the likelihood of this happening.

From the patient's point of view, obtaining mental health treatment services from a non-physician can entail extra cost. In addition, the mobility of Ontario residents means that for many people the general practitioner is the only easily identifiable and preferred contact for help with mental health problems.

About 20 per cent of a general practitioner's time and caseload are devoted to patients with emotional disorders (Schmitz et al, 1979:20). This represents an important source of income to the physician. There are several possible strategies for ensuring that these doctors and their skills are matched with their patients' needs: (1) the general practitioner should be encouraged to refer a patient to non-physician mental health services when these services are appropriate to the patient's needs; (2) the general practitioner should refer to psychiatric services those cases which require more specialized treatment; and (3) the general practitioner should have access to skills upgrading and psychiatric backup so that he or she may be capable of treating more patients with psychiatric diagnoses and thereby reduce pressures on existing specialized psychiatric services.

There are several problems, however, in achieving the first two objectives. On the one hand, the OHIP fee schedule does not allow the physician to bill for time spent searching for or conferring with non-medical mental health service providers, or for time spent supervising support staff in his or her own practice. Therefore, there is little financial incentive for the general practitioner to shift the patient into the non-physician services stream. On the other hand, the general practitioner is not able to bill OHIP for time spent consulting with a psychiatrist about a patient whom the general practitioner would be able to treat properly if specialized psychiatric backup consultation services were available. Therefore, the general practitioner is encouraged by the fee structure either to refer the patient to a psychiatrist or to treat the patient without psychiatric backup consultation.

At the same time, general practitioners might devote a larger proportion of their time to patients with emotional disorders, particularly to patients with chronic mental illnesses, if the financial incentives were stronger. The OHIP fee schedule is structured so that the general practitioner earns more money treating six patients with minor physical disorders for ten minutes each than one patient with a mental health problem for an hour. In short, OHIP offers conflicting incentives to both the general practitioner and to the patient.

One also has to ask about the more serious psychiatric cases which the general practitioner treats, the training he or she has received to treat such cases adequately and the degree of comfort with such cases. Just as the general practitioner is likely to have patients who could be equally well or better served by non-physician services, so too the general practitioner is likely to have patients who would be better served by a psychiatrist. This raises the general question of how best to match the individual patient's needs with the most appropriate skills and resources.

As noted earlier in the discussion of gatekeepers, general practitioners appear not to be diagnosing the mental health needs of a substantial proportion of their patients: 90 out of 230. Some of these may ultimately seek treatment from the non-formal sphere, as might some of the 20/250 who do not seek the assistance of a general physician. It is difficult, however, to obtain data which describe the extent and nature of services provided by professionals who work in the non-formal sphere.

3.2 HOSPITALS

According to the estimates of Goldberg and Huxley (1980), hospitals end up treating on an inpatient basis only a small proportion - about six out of 230, or 2.6 per cent - of those who seek help from a general practitioner. Nonetheless, the bulk of this discussion on treatment is concerned with hospitals. There are several reasons for this emphasis: hospital services absorb more than 50 per cent of the MoH's total expenditures on mental health; hospitals deal with those persons who presumably require inpatient psychiatric treatment because of the severity of their illness; and the availability, type and quality of hospital treatment for the mentally ill have become increasingly contentious issues over the past years.

Fortunately, there is a substantial amount of hospital data available, particularly with respect to inpatient services. Data regarding hospital outpatient services and other non-inpatient mental health services are less available - a serious deficiency in terms of defining and understanding mental health services.

There are four main categories of hospitals providing psychiatric services: provincial psychiatric hospitals (PPH), general hospital psychiatric units (GHPU), general hospitals and community and special psychiatric hospitals (Table III-7).

Hospitals can be categorized according to the schedule of services they provide. Those designated as Schedule 1 psychiatric facilities are mandated to provide comprehensive mental health services as defined in Regulation

Table III-7

Distribution of Ontario Psychiatric Inpatient Facilities: March 31, 1982

	No.	No. of Approved Licensed Beds
Provincial Psychiatric Hospitals (Schedule 1) Range: 237 - 600 beds Average: 492 beds	10	4,917
General Hospital Psychiatric Units (Schedule 1) Range: 17-73 beds* Average: 36 beds	60	2,166
Community/Special Psychiatric** Hospitals (Schedule 1)	4	669
Other***	5	331
TOTAL	79	8,083

* Excluding 1 GHPU with 125 beds. There are two other public hospitals with psychiatric beds - Hearst Notre Dame (2 beds) and The Doctor's Hospital in Toronto (9 beds) - which do not report.

** Royal Ottawa Hospital, Ottawa
Sudbury-Algoma Hospital, Sudbury
Clarke Institute of Psychiatry, Toronto
Homewood Sanitarium, Guelph
(We do not include METFORS in Toronto with 23 beds)

*** Kingston Institute of Psychotherapy (18 beds); Sunnyside Private Hospital, Toronto (12 beds - in August, 1983 this hospital was closed by the Ministry of Health); London Victoria Hospital (257 beds) provides long-term psychiatric care for D.V.A. patients and these beds are not available for general community use; Ottawa Children's Hospital of Eastern Ontario (20 beds); The Hospital for Sick Children (24 beds).

Source: MoH, Hospital Statistics, 1981/82.

609 of the Ontario Mental Health Act. Schedule 1 facilities serve a catchment area of not less then 75,000 people and must provide five essential services:

1. Inpatient services.
2. Outpatient services.
3. Day-care services.
4. Emergency services.
5. Consultative and educational services to local agencies.

Excluded from Table III-7 and subsequent tables are the medical and surgical beds often used for psychiatric treatment in general hospitals which are not Schedule 1 psychiatric facilities. Consequently, Table III-7 underestimates the resources available for inpatient psychiatric services for adults. It has been estimated that some 260 general hospital beds a day across the province are used for psychiatric purposes.(1)

Before examining the specifics of each type of hospital, it is useful to indicate the dynamics of the hospital service component as a whole. There have been important changes in the use of psychiatric facilities over the past 10 years. Between 1977 and 1981, the number of admissions to PPHs decreased while the number of admissions to GHPUs has stabilized at approximately three times that of the PPHs (Table III-8). The substantial rate of admissions to GHPUs and the psychiatric days of care provided by them reflect the major shift of the MoH towards increased use of acute, shorter-term psychiatric beds in facilities in or close to the community of the patient.

Table III-9 describes the distribution of approved psychiatric beds across the province in 1982. Not all these approved beds would be set up and staffed, but the tables can be taken as a reasonably accurate representation of what was available in 1982 and what is still available today. What we find is that

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(1) Dr. Barrie Humphrey, McMaster University, personal communication, 1983.

Table III-8

TRENDS IN PSYCHIATRIC INPATIENT POPULATION

Year	On the Books Start of Period	Admissions	Total Under Care During Period	Discharges	Deaths	On the Books End of Period	Days of Care During Period	Average Daily Population in Hospital
				Psychiatric Hospitals (1)				
1977/78*	5,030	16,575	21,953	16,614	384	4,608	1,956,881	4,301
1978/79	4,608	13,316	18,247	13,287	289	4,357	1,442,683	3,953
1979/80	4,357	12,612	17,467	12,383	266	4,330	1,405,534	3,840
1980/81	4,331	12,665	17,397	12,231	259	4,508	1,405,225	3,850
1981/82	4,520	11,595	17,675	12,285	298	4,514	1,627,174 (2)	3,919
				Psychiatric Units of General Hospitals				
1977/78*	1,343	39,393	40,873	38,122	70	1,758	801,995	1,763
1978/79	1,673	34,870	36,774	34,528	8	1,814	605,694	1,659
1979/80	1,814	35,696	37,424	34,562	27	1,851	667,234	1,823
1980/81	1,856	35,376	37,482	34,480	34	1,950	685,530	1,785
1981/82	1,821	34,123	36,099	33,332	28	1,760	639,172 (3)	1,751
				Community and Miscellaneous Psychiatric Hospitals or Units				
1977/78*	455	5,571	6,033	5,420	1	630	199,763	439
1978/79	817	5,121	6,009	4,684	13	858	308,912	846
1979/80	858	4,870	5,746	4,826	28	730	269,051	735
1980/81	734	4,660	5,413	4,546	23	683	251,378	689
1981/82	794	5,727	6,754	5,622	28	800	290,554 (3)	796

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* 1977/78 was a 15 month reporting period.

(1) Prior to 1981/82, only transfers between psychiatric hospitals were included in the count of transfers. Commencing with 1981/82 data, all transfers between psychiatric hospitals and all other facilities reporting in the system are included in the count.

(2) In 1981/82, days of care during period is for patients on the books, and includes days of care in hospital, in approved homes and on leave of absence.

(3) In 1981/82, the Clarke Institute of Psychiatry changed from the Psychiatric Unit of General Hospitals category to the Community and Miscellaneous Psychiatric Hospitals or Units category.

Table III-9

REGIONAL DISTRIBUTION OF APPROVED PSYCHIATRIC BEDS: 1982

Health Planning Region	Provincial Psychiatric Hospital*		General Hospital Psychiatric Unit**	Community/Special Psychiatric Hospital*	Private*	Other*	Total***	Approved Beds Per Capita
South West	London P.H. St. Thomas P.H.	- 544 - 524 1,078	458				1,526	1:834
Central West	Hamilton P.H.	- 600	406		Guelph, Homewood Sanitarium - 312		1,318	1:1285
Central East	Queen Street M.H.C. Whitby P.H. Penetanguishene M.H.C.	- 600 - 504 - 542 1,646	907	Clarke Institute of Psychiatry, Toronto - 139		Hospital for Sick Children - 24	2,716	1:1345
East	Brockville P.H. Kingston P.H.	- 529 - 437 966	257	Royal Ottawa Hospital - 153	Kingston, Institute of Psycho-therapy - 18	Ottawa, Children's Hospital of Eastern Ontario - 20	1,414	1:838
North East	North Bay P.H.	- 400	94	Sudbury-Algoma Hospital - 65			559	1:1044
North West	Lakehead P.H.	- 237	44				281	1:841
TOTAL		4,917	2,166	357	330	44	7,814	1:1104

* Source: Ministry of Health Hospital Statistics, 1981/82. Private Hospital category does not include Sunnyside Private Hospital (12 beds).
** Source: Ministry of Health Provincial Bed Situation, 1982-1987.
*** Excludes London Victoria Hospital (257 beds).

the per capita availability of psychiatric beds in Central West (Hamilton and area) and Central East (Toronto and area including Penetanguishene) is considerably lower than elsewhere in the province. These figures do not, however, tell the entire story. The Central East region contains about half the psychiatrists and registered psychologists in the province (see Section 9.0, Human Resources) and about half the Community Mental Health Services programs as of November 1982 (Chart III-2.2). Consequently, there are many ambulatory treatment resources available in Central East which are not available in Central West. In the two northern regions, the high per capita ratio of psychiatric beds must be read in the context of the lower numbers of other professional resources in these two regions and of the vast areas which these beds must serve.

Central West (Hamilton and area) has the lowest per capita ratio of psychiatric beds in the province. Most of these beds are located in Hamilton itself which is a major psychiatric centre. I am told that it has been difficult to set up psychiatric beds outside Hamilton because of the problems in attracting psychiatrists to supervise those beds. This is a common problem in all regions. As is discussed in Section 9.0, Human Resources, mental health professionals show a strong tendency to locate in the major urban teaching centres: Toronto, Ottawa, Hamilton, London and Kingston.

In general, most mental health patients in Ontario hospitals are cared for in less than four months. Taken at face value, the data in Tables III-10 to III-12 suggest that, increasingly, PPHs are being used to deal with the more durable and behaviourally difficult cases of mental illness, while the GHPUs and general hospitals are being used to treat acute and more manageable cases. This assumption is supported by the substantial differences in bed turnover. The PPH "turnover rate" was 3.07 (i.e., each bed accommodated 3.07 persons during the year) while in the psychiatric units the rate was 16.33, and 9.13 in other psychiatric facilities (Ontario Ministry of Health, 1981a:17). Almost half (46 per cent) of the separations from PPHs are after a stay of more than one month; 82 per cent of the separations from GHPUs occurred after a stay of less than one month (ibid.:17). Similarly, readmissions to PPHs run to 61 per cent while readmissions to psychiatric units are 45 per cent.(1)

Table III-10

Diagnose of Psychiatric Inpatients: Ontario 1978/79

	Psychiatric Hospitals	Psychiatric Units	Other
Neurosis	7%	38%	16%
Schizophrenia	32%	11%	19%
Other psychosis	20%	23%	21%
Other non-psychosis	17%	15%	19%
Alcoholism	14%	7%	18%
Personality Disorders	11%	5%	8%

Source: Ontario Ministry of Health, 1981a:25.

Table III-11

Marital Status of Ontario Population and of Psychiatric Admissions: 1979/80

	Ontario Population*	Psychiatric Admissions
Married	63%	39%
Single	26%	38%
Separated/Divorced	4%	17%
Other	6%	6%
Total	100%	100%

* Population applies to persons 15 years of age and over.

Source: Ontario Ministry of Health, 1981a:34.

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(1) Published readmission rates need to be treated cautiously. Readmission rates are "event" data not person data; the same person readmitted several times shows up as several readmissions. To have meaning, readmission rates should be based on "person" data and should be established on the basis of the total population served by an institution over its full span of existence. However, the figures quoted here are suitable as a basis for comparing readmissions to the two types of institutions.

Table III-12

Selected Characteristics of Psychiatric Admissions: 1979/80

	Psychiatric Hospitals	Psychiatric Units	Other
Marital Status			
Single	51%	33%	42%
Married	23%	43%	34%
Separated - Divorced	20%	16%	17%
Other	7%	8%	7%
Education			
None or Elementary	33%	19%	21%
Some Secondary	45%	51%	37%
Full Secondary	15%	20%	23%
Post Secondary	7%	11%	20%
Referral Sources			
Medical/Therapist	33%	63%	38%
Self/Family	25%	32%	24%
Psychiatric InPatient	11%	1%	1%
Psychiatric OutPatient	11%	4%	29%
Other		0.1%	2%
Forensic	11%	1%	7%
Sex			
Male	61%	41%	55%
Female	39%	59%	45%
Type of Admission			
Voluntary	65%	95%	85%
Involuntary	31%	5%	11%
Other	4%	0.1%	4%

Source: Ontario Ministry of Health, 1981a.

Also, 52 per cent of all admissions to PPHs were diagnosed as having a psychosis, while only 33 per cent of admissions to GHPUs and 41 per cent of admissions to other facilities (special and community psychiatric hospitals) had a similar diagnosis (Table III-10).

Tables III-11 and III-12 set out the available demographic and social data on hospital inpatients. Table III-11 suggests that among the general population psychiatric admissions are more frequent among the single (never married) and the divorced than among the married. Table III-12 indicates that men, single persons and those with incomplete elementary school education are more likely to be admitted to PPHs. As one would expect, the proportion of involuntary admissions is highest for the PPHs, because they are the best equipped to handle behaviourally difficult patients.

There has, however, been a shift in involuntary admissions over the past few years. Figures for 1981/82 indicate that the proportion of involuntary admissions for PPHs have dropped by about a third to 44 per cent, while the proportion for psychiatric units has increased from five per cent to seven per cent and from 11 per cent to 20 per cent in other psychiatric facilities (MoH Hospital Statistics, 1981/82). These figures suggest a drop in the total number of involuntary admissions; this is likely the result of the effects of the revised Mental Health Act (1978) which imposed more stringent criteria for involuntary admissions.

While there is no doubt that the PPHs tend to deal with the more difficult and durable cases of mental illness, the actual patterns are more complex and are discussed below. One point which should be made here, and which is emphasized throughout this Discussion Paper, is that the rate of admissions and readmissions to all hospitals is related in some measure to the availability of adequate support services in the community.

3.2.1 Provincial Psychiatric Hospitals

The PPHs are unique in that they are the only major psychiatric facilities owned and operated directly by the MoH. Each PPH serves its catchment area. In some cases, the catchment area is reasonably compact; in others, particularly in the north, the geographical distances are substantial. Most PPHs are associated with a Health Sciences Centre, although the nature of the relationship varies from hospital to hospital, from being formalized and strong to informal and weak. Three PPHs - Lakehead, Penetanguishene and Brockville - are not affiliated with a Health Sciences Centre.

3.2.1.1 Services: Core and Specialized

All PPHs provide a similar core of services. But the extent to which they offer specialized programs, and the types of those specialized programs, vary from PPH to PPH (Chart III-6).

For example, all the PPHs offer outpatient services, but the number and scope of outpatient services varies considerably from PPH to PPH. Some PPHs serve only their former inpatients. Others serve both ex-patients and the community at large. Some PPHs have established a number of satellite clinics off hospital grounds; others have not. Queen Street, Lakehead, Whitby and St. Thomas are examples of PPHs which have established satellite clinics in various locations across their catchment areas. Only a few PPHs offer day care services.

There are a number of understandable reasons for these variations. Each PPH provides services for its designated catchment area and, consequently, operates in its own unique environment, serving a particular set of patient populations and providing varying levels and kinds of services in order to meet the needs of that patient population. The PPHs in the north, for example, provide a number of primary and secondary, as well as tertiary psychiatric services, because these services are not available elsewhere in their catchment areas. In the more adequately serviced southern areas, the PPHs tend to concentrate more on tertiary services. In some cases, however, the differences in PPH specialized services have more to do with hospital practices, budget, the hospital administrator's reading of what is most acceptable to the MoH and the predilections of the hospital's medical staff.

3.2.1.2 Admissions and Readmissions

The differences among the various PPHs with respect to admissions and readmissions are worth noting. These data must, however, be treated cautiously. I have found, for example, anecdotal evidence that some number - I do not know how many - of PPH admissions and readmissions are "paper"; that is, the patient is admitted or readmitted simply in order to qualify him or her for a specialized out-patient service or for the Homes for Special Care Program.

Chart III-6

PROVINCIAL PSYCHIATRIC HOSPITALS: SPECIALIZED PROGRAMS 1983

Provincial Psychiatric Hospital	Disturbed Mental Retardation Unit	Inpatient and/or Outpatient Alcohol and/or Drug Program	Child/Adolescent Unit (12 to 20 years)	Children's Outpatient Services	Maximum Secure Division	Medium Secure Units	Forensic Beds
BROCKVILLE	X (29 beds)	X		X		X (40 beds)	
HAMILTON	X (29 beds)						X (6 beds)
KINGSTON		X					
LAKEHEAD		X		X			
LONDON			X (36 beds)*				
NORTH BAY						X (18 beds)	
PENETANGUISHENE	X (32 beds)	X			X (298 beds)		
QUEEN STREET MENTAL HEALTH CENTRE						X (20 beds)	
ST. THOMAS	X (24 beds)	X		X		X (62 beds)	
WHITBY	X (28 beds)		X (16 beds)*	X			

* The services provided by these two programs are purchased by MCSS from the MoH.

Source: MoH, Mental Health Division.

In general, however, admission and readmission rates reflect a well-established pattern of migration to the major psychiatric centres where an array of treatment and support services exists.(1) This pattern has another impact on admission and readmission data. Ex-PPH patients who take up residence in the PPH community are noted as residents of that community when they are readmitted to the PPH. Consequently, the place of origin data for PPH patients tend to overestimate those coming from the major urban centres and to underestimate those coming from the more rural areas. It would be interesting to examine the distribution of patients by the actual municipality of origin of the patient or client, rather than by the site of service delivery. Some municipalities have been reluctant to provide support services, particularly accommodation, for the mental health patient or client. Such an analysis would be helpful in demonstrating to such municipalities that their residents require services, but have to go elsewhere to receive them.

When the patient is released from the PPH, he or she will often remain in the vicinity of the PPH - particularly if a Homes for Special Care bed or inexpensive accommodation and reasonable access to support services are available. The treatment program (including free medication) is also there. The patient tends to stay where the services are. By doing so, he or she loses contact with and reasonable access to the folk and support systems in his or her own community. When help is needed, he or she goes back to the PPH. These factors account for the "silting up" of mentally ill persons around PPHs.

Also, chronically mentally ill ex-PPH patients can become labelled as "psych hospital cases" and are not always accepted by the primary care providers. Consequently, when they go to other providers - for example to a general practitioner or a general hospital - they tend to be referred quickly and directly back to the PPH, without any intermediate stages. Similarly, if they come in contact with the police, the police are very likely to take them directly to the PPH, because of their situation and the nature of the illness, which is one of defensiveness, makes them angry, demanding and often behaviourally difficult.

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(1) Dr. Barrie Humphrey, McMaster University, personal communication, 1983.

Therefore, what the PPH admission and readmission rates reflect are not simply the severity of the mental illnesses of the ex-PPH patients, but also the employment, housing and other mental health services available in the various communities within the PPH's catchment area.

3.2.1.3 Length of Stay

These same factors also influence length of stay. Table III-13 describes Length of Stay (LOS) for the 10 PPHs. LOS is a result of many factors: who is admitted, which itself is influenced by the availability of non-PPH resources, the death rate and the age distribution, just to name the more obvious.

The median length of stay for each hospital has tended to remain reasonably constant from year to year. What is interesting is the substantial differences in LOS among the 10 PPHs, ranging from 14.0 days at Queen Street to 69.5 days at London, with the median for all hospitals in 1981/82 at 38.6 days. There seems to be a tendency for the provincial median to be increasing, from 35.6 in 1978/79 to 38.6 days in 1981/82.

One of the more influential factors in this trend, if it is a trend, may be the scarcity of alternative accommodation for PPH inpatients. The evidence indicates that a significant proportion no longer require inpatient care. A study carried out within the MoH (Singh, 1975) suggested that perhaps 50% of PPH patients did not need to be there. Another study (Richman, Heseltine and Roberts, 1982) came to a similar conclusion about Whitby Psychiatric Hospital. A third study by Medicus Canada (1983) suggests that a smaller but still substantial proportion of the patients in three PPHs could live in a non-hospital setting. The differences between the Medicus Canada study and the previous two are due in large measure to differences in the

Table III-13

PROVINCIAL PSYCHIATRIC HOSPITALS - MEDIAN LENGTH OF STAY SUMMARY: 1978/79 - 1981/82

	78/79	79/80	80/81	81/82
HOSPITALS				
Brockville Psychiatric	26.0	26.0	28.0	35.0
Hamilton Psychiatric	41.5	39.0	34.0	39.0
Kingston Psychiatric	31.0	34.0	37.0	46.0
London Psychiatric	65.0	69.0	71.0	69.5
North Bay Psychiatric	33.0	32.0	32.0	29.0
Penetanguishine M.H. Centre	36.0	34.0	32.0	36.0
Penetanguishine Oakridge	68.0	62.0	71.0	65.0
St. Thomas Psychiatric	33.0	26.0	28.0	26.0
Thunder Bay Lakehead Psych.	32.0	31.0	30.0	31.0
Toronto Lakeshore Psychiatric	10.0	16.0	--	--
Toronto Queen's Street M.H.C.	15.0	16.0	13.0	14.0
Whitby Psychiatric	36.5	23.0	35.0	34.5
Average	35.6	34.0	37.4	38.6

Source: MoH, Data Development and Evaluation Branch, July 1983.

definition of the level of functioning which qualifies a patient as suitable for non-hospital care and accommodation.[1]

Medicus Canada prepared a special analysis of their data for this Discussion Paper (Tables III-14.1 - III-14.2). The three PPHs for which level of care survey data were collected were Lakehead, London and Brockville (see Chart AIII-2 in Appendix A for a description of patient classification levels). First, patients were classified to identify those who were "Low Psychiatric"; that is, patients who did not have a sufficient need for the type of psychiatric treatment which justifies being a PPH inpatient. The percentage of Low Psychiatrics varied considerably among the three PPHs. Lakehead had the lowest rate at 12 per cent, London had 23 per cent and Brockville 32 per cent. None of these patients required hospitalization for their mental illness.

Patients were also classified by Physical Level:

1. Low Physical Level	Patients in this category can live in a minimally supervised setting; for example, in a group home or in some cases at home with their families.
2. Medium Physical Level	Patients in this category usually have some medical problems which require 24- hour supervision and a modest level of nursing care; for example in a home for the aged or a nursing home.
3. High Physical Level	Patients in this category have substantial medical problems and require 24-hour medical services.

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(1) In the Medicus Canada study (1983) patients in the Medium Psychiatric category are not considered suitable for discharge to a community setting. The definition of Medium Psychiatric used is the following: "For patients with a mental illness which does not constitute a hazard to self or others, though it seriously interferes with functional capacity and/or the social competence of self, or a patient whose behaviour is intolerable by prevailing community norms - a 24-hour inpatient setting staffed to provide continuous rehabilitative psychiatric care, supervision and treatment intervention is required".

Table III-14.1

PATIENT MIX - SUMMARY OF PSYCHIATRIC NEEDS: 1983

Psychiatric Level	BROCKVILLE Number Patients	BROCKVILLE % of Average Census	LAKEHEAD Number Patients	LAKEHEAD % of Average Census	LONDON Number Patients	LONDON % of Average Census	THREE HOSPITALS Number Patients	THREE HOSPITALS % of Average Census
LOW	141.7	31.7	20.7	12.3	101.4	23.0	263.8	25.0
MEDIUM	130.1	29.1	22.8	13.6	75.4	17.1	228.3	21.6
HIGH	175.2	39.2	124.5	74.1	264.2	59.9	563.9	53.4
TOTAL	447.0	100.0	168.0	100.0	441.0	100.0	1,062.0	100.0

Note: Patients in the Alcohol and Forensic Programs are not included in these figures.

Source: Data provided by Medicus Canada.

In the case of Lakehead, more than 40 per cent of the Low Psychiatric inpatients fall into Low Physical category. In the case of London PPH, about 19 per cent of the inpatients are both Low Psychiatric and Low Physical and could live at home, in a group home or in some similar accommodation, and 10 per cent are Low Psychiatric and Medium Physical and could live in a nursing home or home for the aged. The remainder of the London Low Psychiatrics fall into the High Physical category.

Brockville PPH has the most arresting figures of the three hospitals. Some 32 per cent of the inpatient population are categorized as Low Psychiatric. Of these, almost all - 91 per cent - are Low and Medium Physical. In other words, of the Brockville PPH population of 447, about 114 could be living at home or in a group home or similar situation (Low Physical), and 16 could be in a nursing home or home for the aged (Medium Physical).

Table III-14.2

THREE PROVINCIAL PSYCHIATRIC HOSPITALS - PHYSICAL LEVELS OF PATIENTS CLASSIFIED AS LOW PSYCHIATRIC: 1983

HOSPITAL	PHYSICAL LEVEL	AVERAGE NO. OF LOW PSYCHIATRIC PATIENTS	% OF LOW PSYCHIATRIC	% OF AVERAGE HOSPITAL CENSUS
BROCKVILLE	LOW	114.0	80	25.5
	MEDIUM	16.1	11	3.6
	HIGH	11.6	8	2.6
	ALL	141.7	100	31.7
LAKEHEAD	LOW	8.9	43	5.3
	MEDIUM	3.9	19	2.3
	HIGH	7.9	38	4.7
	ALL	20.7	100	12.3
LONDON	LOW	84.2	83	19.1
	MEDIUM	10.1	10	2.3
	HIGH	7.1	7	1.6
	ALL	101.4	100	23.0
ALL THREE HOSPITALS COMBINED	LOW	207.1	79	19.6
	MEDIUM	30.1	11	2.9
	HIGH	26.6	10	2.5
	ALL	263.8	100	25.0

Note: Patients in the Alcohol and Forensic programs are not included in these figures.

Source: Data provided by Medicus Canada.

In summary, of the inpatients in these three PPHs, 25 per cent might be discharged to alternative accommodation (Table III-15).

Table III-15

Three Provincial Psychiatric Hospital Populations - Candidates for Alternative Accommodation: 1983

	Number	%
Total Patients in 3 PPHs	1,058*	100%
Home/group home	207	20
Nursing/old age home	30	3
Chronic care	27	3
Total Candidates	264	25%

* Excludes patients in Alcohol and Forensic Programs.

Source: Data provided by Medicus Canada.

One cannot assume that the data from these three PPHs are representative of all 10 PPHs. Nonetheless, the data do suggest that an important proportion of PPH inpatients do not have psychiatric conditions which necessitate hospitalization.

The real issue is where else these inpatients can live and still receive a level of care and support services appropriate to their needs. High Physical Level patients require a hospital setting; chronic care hospitals are full, have long waiting lists and seem to prefer to admit those who are not ex-PPH inpatients. Similarly, nursing homes and homes for the aged (Medium Physical) have long waiting lists and group homes (Low Physical) are in short supply and not well distributed across the province.(1)

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(1) The figures on empty beds are sobering. Of the total of 4,472 PPH beds set up in March 1982, 3,998 or 89 per cent were occupied (MoH, Data Development and Evaluation). Of the 4,216 staffed chronic care beds in March 1982, less than 4 per cent were empty (MoH, Hospital Statistics, 1981/82). Of the 17,536 licensed nursing home beds in 1981/82, only 62 or 0.4 per cent were empty (Ernst and Whinney, 1982).

3.2.1.4 Image and Quality of Care

This discussion should be prefaced by noting that the PPHs have been the conventional whipping boys of critics of mental health services. The PPHs have a poor image. In part, the reasons for this are historical. Until OHIP was put in place, a PPH was often the only psychiatric service a patient could afford, and the hospitals developed a reputation as a place of last resort for the poor, the needy and the disorderly. In large part, this pre-OHIP reputation has persisted. In addition, to the extent that the PPHs must, perforce, deal with the most severly behaviourly disturbed and durable cases of psychiatric illness, it has not been easy to change that reputation.

We still have in Ontario the vestiges of a two-tier psychiatric service system in which the poor and less advantaged tend to use the PPHs, while the more affluent and more socially adept tend to use the GHPUs, the general hospitals, special or private psychiatric facilities or their own psychiatrists and therapists. Some general practitioners and GHPUs may contribute to this two-tier arrangement simply because of their own, often unacknowledged, social predilections - particularly if the client is poor, socially inept and presents a behavioural management problem. This two-tiered arrangement is reinforced by staffing problems in the PPHs which are discussed below.

The poor image of the PPHs is also based upon complaints by some sectors of the public about the perceived quality of care and treatment of inpatients. These cover the gamut from opposition in principle to specific allegations: psychiatric hospitals make people ill rather than help them; no psychiatric patient requires inpatient treatment in a psychiatric hospital and all those who require treatment should receive it in the community (except for forensic cases); standards vary excessively from PPH to PPH; the standards of treatment are inadequate at best and usually poor, with an undue emphasis on the use of drugs and other methods to control patients.

Practically speaking, one has to disregard those criticisms of the PPHs which are grounded in the belief that psychiatric institutions are unnecessary or, by their very nature, "bad". The point has already been emphasized several times that a psychiatric hospital setting will always be necessary for some small proportion of the population.

For the most part, PPH front-line staff are doing a most creditable job given the problems related to funding, management and staffing. There is evidence, however, suggesting that not all PPHs are doing all they are expected to do in the way of providing consistently high standards of appropriate treatment and care for their patients. A recent study of three PPHs found that very little group or individual therapy is provided for patients in most programs, that only a limited effort has been devoted to formal program development or evaluation, and that inadequate attention has been given to patient discharge planning and out-placement (Medicus, 1983). These findings are also likely to apply to some of the other PPHs. A number of actions by the Ministry indicate that it is now taking these problems seriously.

Medical and other staffing ratios, other than nursing, vary widely from hospital to hospital (Table III-16). For example, ratios of psychiatrists to patients range from 1:14 at Queen Street to 1:80 at Brockville; the ratio of psychologists ranges from 1:15 at the Lakehead to 1:54 at Brockville. To some extent these variations may be more apparent than real because they are based on inpatient populations and do not take into account outpatient services. Nonetheless, the differences are striking and suggest both an inadequate and an inequitable distribution of resources which is, in part at least, a reflection of the difficulty that some PPHs have in recruiting professional staff, particularly psychiatric staff.

There are also variations with respect to the percentage of "open door beds" (22 per cent to 71 per cent), and with respect to patients absent on weekend leave (2 per cent to 14 per cent). These variations may be due to such straightforward considerations as patient characteristics. It is reasonable to assume, however, that some of these variations have less to do with the patients' characteristics and more to do with the way the individual PPHs operate.

Table III-16

PROVINCIAL PSYCHIATRIC HOSPITALS - STAFFING AND OTHER CHARACTERISTICS: 1981

Provincial Psychiatric Hospital	Patients	Medicine		Psychiatry		Psychology		Social Work		Occup. & Physio.		Rec. & Voc. Therapy		Nursing	
		Actl. #	per pt. ratio	Actl. #	per pt. ratio	Actl. #	per pt. ratio	Actl. #	per pt. ratio	Actl. #	per pt. ratio	Actl. #	per pt.. ratio	Actl. #	per pt. ratio
Brockville	483	8	1:60	6	1:80	9	1:54	11	1:44	2	1:242	36	1:13	337	1:1.4
Hamilton	343	1	1:343	18	1:19	11	1:31	25	1:14		48**	1:7		300	1:1.1
Kingston	368	2	1:184	13	1:28	16	1:23	22	1:17	12.5	1:29	23	1:16	316	1:1.2
Lakehead	182	5	1:36	6	1:30	12	1:15	14	1:13	9	1:20	16	1:11	161	1:1.1
London	446	3	1:149	20	1:22	13	1:34	27	1:17	15	1:30	26	1:17	363	1:1.2
North Bay	264		7*	1:38		10	1:26	14	1:19	4	1:66	29	1:9	212	1:1.2
Penetanguishene & Oakridge	477	11	1:43	9	1:53	18	1:27	28	1:17	11	1:43	41	1:12	354	1:1.3
Queen Street	554	13	1:43	40	1:14	25	1:22	50.5	1:11	27.5	1:20	55	1:10	554	1:1
St. Thomas	409	2	1:205	16	1:26	15	1:27	27	1:15	13	1:31	40	1:10	367	1:1.1
Whitby	381	9	1:42	10	1:38	12	1:32	20	1:19	13	1:29	28	1:14	292	1:1.3

* Medical/psychiatric staff combined.

** Occupational, Physio., Recreational and Vocational combined.

	% of open door beds	Average % of patients absent on weekend leaves
Brockville	22	4
Hamilton	60	14
Kingston	N/A	N/A
Lakehead	95	4
London	64	10
North Bay	45	3
Penetanguishene	71	2
Queen Street	70	13
St. Thomas	27	7
Whitby	25	14

Source: MoH, Mental Health Division

All psychiatric facilities are faced with the difficult question of how best to exercise adequate control over patients whose illnesses and behaviours vary considerably. In the case of the PPHs, the problem is intensified because between 40 per cent and 70 per cent of their patient populations have high psychiatric needs.(1) The wards tend to be large and often contain an improper patient mix. As a consequence, the doors often have to be locked on many to contain a few.

The need exists to protect all patients and staff from those on the ward who present a management problem. This can be achieved through high staff-patient ratios, chemical restraint, physical restraint and/or locked wards. A high staffing level is the most desirable method, but because of the costs involved, the use of drugs is sometimes chosen as the way to achieve the necessary level of control. This can be the source of anger and resentment among affected patients, and of concern to the community at large.

Recognizing the need to ensure patients' legal rights, in mid-1983, the Ministry established a Patient Advocate program in PPHs. Eleven advocates with backgrounds in nursing, social work or law were appointed, one to each of nine PPHs and two to Queen Street. The responsibilities of the patient advocate include the following: to investigate and direct inquiries and complaints to appropriate hospital staff members and act as an intermediary to hospital administration on behalf of patients and their families and to assist in referring patients to appropriate services (e.g., legal aid, family physicians). The advocates report to the Co-ordinator of the Patient Advocate Program, who reports to the Deputy Minister of Health.

Even at this early stage of the operation of the program, it is possible to discern problems with the role of the advocate. The most serious is the advocate's relationship with PPH staff. There have been reports of instances in which the advocate informed the patient of his or her rights and the patient decided to withhold consent for treatment when the staff believed that treatment was necessary. This is not a surprising consequence of the introduction of the program; however, it does point to the need to clarify the respective roles and responsibilities of the patient, the advocate and the doctor and to improve communications between the staff and the advocates.

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(1) This estimate is extrapolated from Medicus Canada (1983) data. See Table III-14.1.

3.2.1.5 Funding

The budgets of the PPHs have increased from $158.4 million in 1978/79 to $193.6 in 1981/82 (preliminary), a substantial increase in absolute dollars. The percentage increase, however, is only 20 per cent over the three-year period which is lower than the rate of inflation during that time period. There may be, therefore, some justification for the frequently-heard complaint from the PPHs that they are being "starved". In addition, in the past year (October 1982 - October 1983), the province's inflation restraint program has resulted in a maximum of a five per cent salary increase for public sector workers. This may have made it even more difficult than usual for some PPHs to attract qualified medical, nursing and other professional staff.

PPH Administrators also claim that the existing budget procedures are artificial and futile. The results, they suggest, are not monitored by the MoH to assess budget proposals vis-a-vis overall program provision. It is my belief that the budgets are also not systematically monitored by the individual PPHs; some PPHs, without consulting clinical staff, will simply cut whole programs to accommodate budget limitations rather than attempt to distribute the cuts across a variety of programs.

The conventional wisdom holds that the answers to the PPHs' problems lie in more funding. That may be so, but I am reluctant to base recommendations upon the assumption that substantial increases in funding to the PPHs will actually be provided, given current economic conditions. Adequate funding is important if the PPHs are to continue to carry out a more community-oriented mandate effectively. But it seems more realistic to suggest that the first step is to make the best use of all the available mental health resources in each catchment area, and that any proposals for additional PPH funding should take these other resources into account. In other words, comprehensive and coordinated planning is required. This includes an improved definition by each PPH of its role or roles in its catchment area, roles which should be defined in the context of district and regional mental health priorities and resources.

3.2.1.6 Management

There are problems within the PPHs with respect to internal hospital and program management. The Medicus Canada study (1983) documents these problems in three PPHs, and they likely apply equally to other PPHs. With respect to overall hospital management, the study finds that the three hospitals do not have clearly articulated statements on two fundamental matters: philosophy and level of care staff should provide to patients. The study also documents a number of areas for senior management to improve the processes of care delivery. These include: (1) definition of the types and quantities of services which patients require; (2) decisions on the appropriate roles and activities of each patient care discipline; and (3) implementation of management processes for making budgetting and staffing decisions.

With respect to program management, the study states that more structured direction and control are required in each of the three hospitals for each program. One aspect is that the authority of the Medical Unit Head of each program is not clear vis-a-vis staffing and programming decisions. A second aspect is that the management skills of the Unit Heads need improvement.

The PPHs are owned and operated directly by MoH, and this too has created some difficulties. There are diverse reporting relationships between the PPHs and the provincial government. The PPH Administrator reports to the Executive Director of the Mental Health Division via the Operations Branch of the Mental Health Division on matters of day-to-day operations, including the Homes for Special Care program and new hospital programs. On matters pertaining to physical plant, the Administrator may deal directly with Ministry of Government Services which owns the plant or go through the Supply and Services Branch of the MoH.

The MoH does not involve itself in matters of clinical decision-making. It can, however, have an impact on clinical practice because it requires that the PPHs submit to it for approval all their proposals for new programs. The approval process can be lengthy and thereby affect the PPH's ability to respond to emerging needs.

On matters pertaining to staffing, the reporting relationship depends upon the classification. The hiring of the PPH Administrator, and anyone else above the A.M. 15 classification (Medical Director, Administrator, Assistant Administrator), must be approved by the "A" Committee of the Ministry. The Committee does not, in the opinion of many PPH Administrators, meet frequently enough to process the applications speedily. The PPH Administrator hires professional, direct service and other staff with the assistance of the MoH's regional personnel administrator who is located in the PPH and reports to the Human Resources Branch of the Ministry.

These reporting and approval procedures reflect the MOH's need to ensure accountability and intra-Ministry co-ordination and make sense in organizational or Ministry terms. These procedures do, however, present problems for the PPHs with respect to their staffing needs and to their ability to respond quickly to the circumstances and requirements of their respective catchment areas.

In order to encourage interaction with their local catchment areas, in early 1983 the Ministry established a Community Advisory Board (CAB) for each PPH. The CAB's mandate can be summarized as follows:

- Community awareness/understanding. Interpreting the PPH to the community and paving the way for greater acceptance of patients before and after discharge.

- Liaison. Improving interaction between the PPH and other mental health service and related providers in the catchment area, including accommodation, counselling, outreach and employment, as well as the more traditional in-patient programs; facilitating working agreements between the PPH and these agencies and monitoring these agreements.

- Community input. Identifying local attitudes, needs and concerns to which the PPH should respond and encouraging co- ordination and co-operation with the District Health Councils in developing a "rational picture of the catchment area needs".

- Hospital programs. Reviewing and monitoring PPH programs to determine whether they are meeting catchment area needs; recommending changes in PPH programs and endorsing new programs in response to community attitudes, needs and concerns; and co-ordinating with the District Health Councils.

- Patients' rights. Reviewing PPH processes and patient advocate reports and recommending changes if necessary.

The CAB mandate is, on paper, a formidable one. A CAB has the authority to review and make recommendations on most aspects of the PPH's internal and external operations, including hospital programs, patient rights, co- ordination with DHC and mental health service providers. It also reports directly to the Minister of Health.

Currently, most of the CABs are concentrating on improving communications between the PPHs and the mental health service providers in their respective catchment areas. It remains to be seen how each CAB will interpret and act upon the broader and potentially more influential aspects of their mandate. The creation of the CABs is a positive step towards opening up the PPHs and the community to each other and facilitating the integration of the PPH into district and regional mental health services.

3.2.1.7 Recruitment

Morale in the PPHs is often poor, particularly among the medical and other professional staff. This situation needs to be corrected if the required quality of service is to be provided.

Although it is difficult to obtain figures, it is plain that some PPHs are having difficulty recruiting qualified medical and psychiatric staff. There are a number of reasons for this problem. The PPHs often are geographically and professionally isolated. A PPH appointment is often perceived as not of high professional status and is often not a physician's first choice. A number of medical staff are working on a special license which precludes them from working in other than a PPH program and so they have limited opportunities to develop as professionals. Medical staff have less authority, less independence and a more difficult mix of patients than they would have in a community psychiatric or general hospital, and this reduces the level of job satisfaction. Hospital civil service regulations abound. Planning and decision-making are centralized in the MoH, a process which is not always highly sensitive to individual hospital requirements. It is also a lengthy process, which can be a source of great frustration for medical staff.

PPHs do hire psychiatrists on a sessional basis. A session must be a minimum three-hour block of time, but often is longer than three hours. Nonetheless, the sessional fee is standard across the PPHs - $179 per session - and is much below what a psychiatrist can earn treating private patients. Therefore, it is difficult to attract private psychiatrists to work for PPHs on a sessional basis. The contract arrangement is somewhat more attractive to psychiatrists working in a university setting. Such a psychiatrist can earn an outside income up to a stipulated level. When that psychiatrist exceeds the limit, the excess is turned over to the hospital which can use it to support education, research staff or other resources which, in turn, can be made available to the psychiatrist to increase job satisfaction.

There appears to be a new Ministry practice of hiring medical staff, at least at the medical director level, on contract rather than on salary in an attempt to make employment in the PPHs more financially attractive. From the Ministry's point of view, this practice has the added advantage of allowing greater control over physician performance; standards can be specified and contracts are limited in duration.

3.2.1.8 Forensic Psychiatric Services

No discussion of the practices, image and future of the provincial psychiatric hospitals is complete without reference to the role which they play in the provision of forensic services. Forensic psychiatry is that branch of psychiatry which deals with the assessment, diagnosis and treatment of mental disorders in individuals who are in conflict with the law. Forensic services, by their very definition, require an interface between the criminal justice system and general mental health services.

Several Ministries are involved directly in planning and providing forensic services in Ontario - Health, the Attorney General and Correctional Services; the Ministry of the Solicitor General and the Secretariat for Justice are also involved, although less directly. Thus, there is a fragmentation of jurisdiction and administrative responsibility in this service area, a fragmentation which leads to a lack of clarity as to who is responsible for mental health services in relation to the mentally disordered offender. The involvement of the three major Ministries in the provision of forensic services is reviewed below.

Ministry of Health. Table III-17 shows the distribution of forensic psychiatric services funded by the MoH. Most of these services are provided in provincial psychiatric hospitals.

The Oak Ridge Division of Penetanguishene Mental Health Centre is the only maximum secure treatment unit in the province. The Division has 295 beds and admits patients from the entire province and also, on occasion, from outside the province. The Division treats the following patient categories:

(1) Warrants of the Lieutenant Governor (L.G.W.);(1)

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(1) Only male L.G.W. patients are admitted to this facility. Women who are subject to an L.G.W. are usually admitted to the medium secure unit at St. Thomas Psychiatric Hospital.

Table III-17

Distribution of Ministry of Health Forensic Psychiatric Services: 1983

	Maximum Secure Division	Medium Secure Units	Other Forensic Beds
South West	Penetanguishene Mental Health Centre, Oak Ridge Division (295 beds)	St. Thomas Psychiatric Hospital (62 beds)	
Central West			Hamilton Psychiatric Hospital (6 beds)
Central East			Clarke Institute of Psychiatry (22 beds) Queen Street Mental Health Centre* (20 beds)
East		Brockville Psychiatric Hospital (40 beds)	Royal Ottawa Hospital (16 beds)
North East		North Bay Psychiatric Hospital (18 beds)	
North West			

* These beds are used primarily for the hospital's own patients who require a short-term safely-keep setting.

Source: MoH, Mental Health Division.

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(2) Patients held on certificates (involuntary status) transferred from other psychiatric facilities, general hospitals and correctional institutions under the Mental Health Act;

(3) Warrants of Remand (W.O.R.) for psychiatric assessment for a period of 30 to 60 days after which the patient is returned to Court for trial and/or sentencing.

For February 1983, the occupancy rate in the Oak Ridge Division was 89% and included:

Warrants of the Lieutenant Governor = 121 (46%)
Certificates = 121 (46%)
Warrants of Remand = 21 (8%)
263 (100%)

The trend over the last few years has been for a decreasing number of patients from Ontario's correctional institutions to be admitted to Oak Ridge. As of January 1, 1983, 42 per cent of Oak Ridge's patient population came from PPHs, while only four per cent came from correctional institutions. The immediate referral source for the majority of the remaining patients was the courts (48 per cent). Only a small portion (three per cent) came from general hospitals. As of January 1, 1983, almost 70 per cent of the patients were diagnosed as psychotic and 27 per cent as personality disordered.

Approximately 30 new L.G.W. patients are admitted to Oak Ridge each year, while another 20 or so are readmitted from other PPHs. Only a small number of male persons have their original Warrant drafted to permit their detention in a medium secure unit of a PPH. Thus, most new L.G.W.s are admitted to Oak Ridge.

The case of each L.G.W. patient is reviewed annually by the Advisory Review Board. The Board was created in 1967 under the Mental Health Act and is composed of a judge or a retired judge of the Supreme Court who serves as chairman, a psychiatrist and three other members. The Board's responsibility is to make recommendations to the Lieutenant Governor in Council as to whether the conditions of the patient's warrant should remain as is, be loosened to allow for a transfer to a less secure setting, or be vacated. If the Board recommends that the warrant be loosened, the Oak Ridge patient is most often transferred to the medium secure unit at St. Thomas Psychiatric Hospital. Less frequently, L.G.W. patients on loosened warrants are transferred to the medium secure units at Brockville or North Bay Psychiatric Hospitals. The patient may subsequently be transferred at a later date to the regular wards of a psychiatric hospital. Patients tend to remain in the medium secure units longer than one year and, therefore, these units are able to accept increasingly limited numbers of transfers each year from Oak Ridge.

There is in Ontario a tendency to send almost all L.G.W.s to Oak Ridge initially whether they require maximum security or not (Phillips et al, 1983:150), although there are indications that this is changing. One study has suggested that many patients admitted to Oak Ridge could be assessed and treated in a less than maximum secure setting (Butler and Dunbar, 1978). This applies both to those patients admitted on an L.G.W. and those patients transferred from other psychiatric hospitals because of management problems.

In addition to the maximum secure forensic services provided by Penetanguishene Mental Health Centre, medium secure units are located in three other PPHs. One other PPH, the Clarke Institute, and the Royal Ottawa Hospital also provide inpatient assessment and treatment services to persons referred by the courts and correctional institutions. The distribution of these forensic services is shown in Table III-17. It was estimated in 1979 that between 500 and 600 psychiatric examinations a year are conducted in these facilities (The Ontario Council of Health, 1979a:121).

Ministry of the Attorney General. The Ministry of the A.G.'s primary involvement in the provision of forensic psychiatric services is through the funding of the Metropolitan Toronto Forensic Service (METFORS) established in 1977 and located at Queen Street Mental Health Centre. It consists of a Brief Assessment Unit (BAU), which provides rapid psychiatric assessments for those appearing in Judicial District of York criminal courts and who have been identified as having serious psychiatric and emotional problems, and a 23-bed inpatient unit for those patients who require a more extensive assessment. In 1982, 594 patients were assessed in the B.A.U. and 277 patients were admitted to the inpatient unit.

METFORS is operated by the Clarke Institute of Psychiatry. It is administered by a five-member board representing METFORS, Ministries of the Attorney General, Health, and Correctional Services, and the Clarke Institute. The board reports annually to the Attorney General.

Ministry of Correctional Services. The Ministry of Correctional Services provides funds to its institutions to employ private psychiatrists on a fee-for-service basis as needed. In addition, the Ministry operates the Ontario Correctional Institute in Brampton and the Guelph Assessment and Treatment Unit, each of which provides specialized psychiatric services to their offender populations.

Two major problem areas are identifiable. As Table III-17 indicates, there is an uneven distribution of medium secure forensic beds across the province. In addition, there is no interministry mechanism to facilitate the planning, co-ordination and delivery of a comprehensive network of forensic psychiatric services, and to clarify the responsibility for mental health services to persons involved in the criminal justice process.

3.2.2 General Hospital Psychiatric Units (GHPUs)

About 25 per cent of all general hospitals in the province have psychiatric units; currently there are some 60 general hospital psychiatric units with 2,155 beds. Funding is provided through the MoH Institutional Division and policy development falls under the Mental Health Division.

The GHPUs are not intended to substitute for the services provided in the provincial psychiatric hospitals. Their purpose is to provide acute and short- term care in the community, or close to the community, of the patient. As Table III-8 indicates, the GHPUs play an important role in the delivery of mental health services close to home for those who require an inpatient setting. Admissions have increased from 17,400 admissions in 1969 to 34,123 in 1981/82 and have remained relatively stable at about 34,000 to 35,000 for the past five years. The bed turnover rate (1979/80) is 16.33, denoting the relatively short length of stay for most patients - usually less than one month (Ontario Ministry of Health, 1981a:17). Many GHPUs do not report comprehensive data on outpatient services.

Table III-18 sets out the distribution of patients by diagnosis in GHPUs over the past 10 years. These figures show that the GHPUs (including general hospital medical and surgical beds) are treating an increasing proportion of the more seriously mentally ill, and not simply the "worried well' and "nicely neurotic". Because the ability of the GHPUs to manage highly behaviourally disturbed or difficult psychiatric cases is limited, they sometimes refer these patients to the nearest PPH.

The position of the GHPUs has been the cause of some concern to many. Each GHPU is required to offer Schedule 1 services: inpatient and outpatient treatment services, day-care, emergency services and consultation and education for local mental health agencies. But, the type and amount of these services provided by each of the GHPUs varies considerably. A survey of the GHPUs, conducted by the newly-formed Association of General Hospital Psychiatric Services, is underway to identify precisely what Schedule I and other services the GHPUs are providing.

It appears that many GHPUs are not providing all the essential services called for under their Schedule I mandate. The essential services which seem to be most often lacking are emergency and outpatient, and there are indications that some GHPUs are also not providing consultation and education for local mental health agencies because, it is argued, their budgets do not permit them to provide such services.

Effective psychiatric emergency services are the least well-provided by Schedule I general hospitals at this time. Emergency services include the capability to respond to a psychiatric crisis which, in turn, necessitates provision for safely-keep: that is, a place where patients who present a management problem can be isolated from other patients, protected from themselves and stabilized so that a full assessment can be carried out. My information is that none of the GHPUs have appropriate safely-keep or special observation facilities for those patients who need to be separated from the others. The findings of the GHPU survey currently underway should clarify this situation.

Table III-18

Selected Disorders, Separations by Selected Diagnosis Groups, General Hospitals: Ontario 1972 - 1980/81*

	1972	1980/81
Psychotic Disorders		
Schizophrenia	8.6%	10.7%
Affective Psychoses	10.4%	11.1%
Other Psychoses	4.1%	9.1%
Total Psychotic Disorders	23.1%	30.9%
Non-Psychotic Disorders		
Neuroses	42%	27.2%
Alcoholic Disorders	19.7%	16.5%
Other Non-Psychotic	15.3%	25.4%
Total Non-Psychotic Disorders	77.0%	69.1%

* Includes GHPUs and general hospital medical and surgical beds.

Source: Data provided by Mr. Rod Riley, Statistics Division, Health and Welfare Canada.

Each GHPU currently defines its responsibilities as it sees fit within the resources available to it and within the general mandate which its hospital board is willing to accept. There is considerable tension in many general hospitals which have psychiatric units between the medical staff of the psychiatric unit and the medical staff of the hospital with respect to the division of available resources.

The psychiatric unit's budget is buried in the hospital's global budget and it is difficult to ascertain the amount of the general hospital budget allocated to the psychiatric unit. Psychiatrists, social workers and others typically associated with the delivery of mental health services in a general hospital do not always have a high status in the hospital hierarchy. There is evidence that the psychiatric units are often squeezed at budget time more than are other hospital departments. Also, the ability of a GHPU to provide required services is influenced by the need to obtain the consent of the hospital board which is not always cognizant of or deeply concerned about the mental health requirements of the hospital's catchment area - although some hospital boards have established mental health committees to deal specifically with this service component.

In October 1982, the Minister of Health noted that some general hospital boards were not passing on to their psychiatric units their full share of the hospitals' global budget increases. The Minister asked all hospital boards to maintain the appropriate budget allocations to their psychiatric units and stated that no budget reductions for psychiatric services could go forward without the prior approval of the MoH (Grossman, October 29, 1982). Informal monitoring of this situation by the Mental Health and Institutional Divisions suggests that the general hospitals are complying with the Minister's request.

Among the problems faced by the GHPUs has been the absence of guidelines on programs or accountability for programs. It is expected that the formation of the Association will provide a mechanism to resolve this problem in conjunction with the Ministry. The Association is also discussing with the Ministry the provision of funds for non-billable time spent by Chiefs of Service of GHPUs on organizational and administrative duties associated with their position.

The relations between the GHPUs and the other mental health service providers in their communities vary so greatly that it is difficult to draw any useful generalizations. Some GHPUs are working closely with other community mental health providers: for example, Oakville-Trafalgar Memorial, Hamilton General, Kitchener-Waterloo. For most GHPUs, however, there is not yet enough information available to comment.

3.2.3 General Hospitals

Many general hospitals across the province also provide limited, short-term, psychiatric services using available medical and surgical beds.

In rural areas distant from a psychiatric center, a large proportion of admissions under psychiatric diagnosis are to non-psychiatric general hospital beds. By contrast, in major urban areas with a number of psychiatric facilities, comparatively few admissions are made to such units. Stays in these non-specialized units tend to be brief, in the order of seven to eight days. According to one estimate, at any one time in 1980/81 approximately 260 general hospital beds outside psychiatric units were occupied by persons with psychiatric diagnoses.(1)

Although Ontario data are not at hand, available national statistics indicate that, in 1975, non-psychiatric wards of general hospitals accounted for 80,700 psychiatric discharges; that is, 39 per cent of all their inpatient events were attributable to mental disorders (Cardillo, 1980). These general hospitals without psychiatric units tended not to treat cases diagnosed as psychotic or personality disordered. Rather, the highest incidence of diagnosis in these hospitals was neuroses (about 35 per cent) followed closely by alcoholism (30 per cent). It is interesting that the majority of diagnosed alcoholism cases were men (81 per cent) and most of the diagnosed neurotics were women (73 per cent) as were most of the affective psychotic diagnoses (73 per cent) (ibid.).(2)

There is so little information on treatment standards and procedures, discharge planning and other matters in these general hospitals that it is difficult to comment further on their provision of psychiatric services.

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(1) Based on data collected by Dr. Barrie Humphrey, McMaster University.

(2) Because figures are from 1975, one cannot determine to what extent the same pattern of diagnoses exist today. But, given the influence Ontario has on Canadian averages, it is likely that they were fairly representative of the situation in Ontario at that time.

3.2.4 Other Hospitals

There are currently five psychiatric institutions which do not fall into the categories described above.(1) These include two community psychiatric hospitals, one special psychiatric hospital, and two private hospitals, one of which, Homewood, is a Schedule 1 facility.

The two community hospitals are the Royal Ottawa and Sudbury-Algoma. These were originally tuberculosis sanitaria and are now Schedule I facilities offering a range of inpatient and outpatient psychiatric services. Both also have a Regional Children's Centre to complement their adult psychiatric services. Both are affiliated teaching hospitals and are used to train postgraduate students in psychiatry as well as allied health professionals. Each serves a catchment area which is relatively local. For example, approximately 80 per cent of the Royal Ottawa's patients come from the Ottawa-Carleton health district.

The Clarke Institute of Psychiatry is a Schedule I facility, established in Toronto in 1966 under the Ontario Mental Health Foundation Act to "maintain, manage and operate a hospital with facilities for psychiatric research, education, diagnosis and treatment". The Clarke operates as a public hospital with its own Board of Trustees, and is formally affiliated with the University of Toronto as a teaching hospital. As a matter of practice the University of Toronto Department of Psychiatry is deeply imbedded in the Clarke. It has become customary, for example, for the Director of the Clarke to be also the Professor and Chairman of the U of T Department of Psychiatry. Also, all medical staff at the Clarke have academic appointments at the University.

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(1) In addition, there are several hospitals which, while not designated as psychiatric institutions, do provide important mental health services. These include The Donwood Hospital and the Clinical Institute of the Addiction Research Foundation. Psychiatric services are also provided in Ottawa by the National Defence Medical Centre which is a federal facility.

The Clarke has the largest concentration of academic psychiatrists in Canada. Although a substantial proportion of its patients come from the Metro Toronto region, because of its specialized programs - for example, for sex offenders - it draws patients from across the province. The inpatient service consists of 139 beds and the outpatient service reported more than 110,000 visits during 1980/81 (Clarke Institute of Psychiatry, Annual Report, 1980/81).

In addition to two general adult psychiatric units, the Clarke has units specializing in affective disorders, psychogeriatric, psychosomatic and forensic psychiatry. The Clarke's Forensic Division constitutes an important provider of forensic psychiatric services, particularly in the Metro Toronto area. Services include inpatient and outpatient assessment, diagnosis and treatment services which are employed by the courts and the legal profession. The Family Court Clinic provides assessment and treatment services to children, adolescents and families referred by the Provincial Courts (Family Division). The Clarke also operates the Attorney General- funded service METFORS which includes the Brief Assessment Unit and a 23-bed unit for longer-term assessments.

The Clarke's Primary Care Service provides a 24-hour, seven day a week, multidisciplinary emergency and drop-in service which is one of the more effective crisis intervention services in the province. Through its Social and Community Psychiatric Section, the Clarke also helps to identify gaps in community psychiatric services in the Metro Toronto area and provides consultation to agencies.

The status of the Clarke Institute is anomalous. The statute establishing the Clarke is the Ontario Mental Health Foundation Act. The Act calls for the OMHF to appoint two of its Board members to the Board of the Clarke and for the OMHF to prepare a list of nominees from among which the Board of the Clarke is to be constituted. The by-laws, rules and regulations of the Clarke are to be subject to the approval of the OMHF, its budget estimates submitted to the OMHF, and its annual reports submitted to both the Minister of Health and to the OMHF. It appears, therefore, that the original intention of the provincial government was to have the OMHF exercise some significant degree of control or influence over the Clarke. But, the wording of the statute does not spell out what actions the OMHF is required to take following the reception of the budget estimates and annual reports.

It is my understanding that the OMHF has not exercised its responsibilities vis-a-vis the Clarke in any effective manner, perhaps because of the absence of clear guidelines. The Clarke submits to the OMHF, as a matter of formality, the names of those persons it wishes appointed to the Clarke Board. Similarly, the Clarke's budget is prepared independently of the OMHF and a copy is sent to the OMHF "as a matter of courtesy".

Homewood Sanitarium, established in 1883, was the first private psychiatric hospital in Ontario and is the largest such hospital in Canada. For its first 80 years, it was the only institution in Canada where the treatment of alcoholism was a primary focus. It is now a Schedule I facility and provides general psychiatric services as well as specialized services in the areas of addictions and psychogeriatrics. Homewood itself offers inpatient services; it also operates a Community Mental Health Centre under a separate board. Also, Homewood staff operate an outreach program in Cochrane and provide consultation to Dufferin and Wellington nursing homes. Homewood meets many of the psychiatric service needs of the people of Dufferin and Wellington, and also draws patients from other parts of the province, particularly for its addiction treatment program. Homewood has never received capital funds from the provincial government. The basic operation is funded by the MoH in a manner similar to any other public general hospital. The outpatient services provided by its Community Mental Health Centre are billed directly to OHIP.

3.3 OTHER ADULT OUTPATIENT TREATMENT SERVICES

Hospitals are not the only organizations providing outpatient services to the community at large. In addition to the hospital outpatient treatment services described above, there were, as of September 1983, 64 treatment programs across the province funded by the Ministry of Health, Community Mental Health Services Program (CMHS). One of the criteria for CMHS funding is that the parent organization of the program must be based in the community. If the sponsor is a hospital, the program must be administered under a separate committee. The great majority of these CMHS treatment services are associated with hospitals, and, in some cases, with public health units. In addition to treatment, they often provide other clinical services such as assessment, diagnosis and referral. Like all CMHS-funded programs, these outpatient treatment services include an evaluation component. The geographical distribution of these programs across the province is uneven (Chart III-2.3).

CMHS also funds nine psychogeriatric programs which provide a range of outpatient services to psychiatrically disabled elderly people and their families. Some of these programs are associated with general hospital psychiatric units. There is a serious shortage of specialized non-inpatient services at the local level for the elderly population, a shortage which will become increasingly acute as the proportion of elderly in our population continues to increase.

Other non-profit organizations, such as family service agencies, constitute important front-line mental health treatment resources. Providing individual and family counselling, these agencies are funded mainly by community contributions through the United Way, with other funds obtained from Ministry of Community and Social Services and user fees. The 33 agencies which belonged to the Ontario Association of Family Service Agencies in 1980, and which served a combined population of 7,022,224, are reported to have dealt with 47,403 cases and 128,547 persons in that year.

3.4 ALCOHOL AND DRUG TREATMENT SERVICES

There has been considerable discussion among researchers about the relationship, or non-relationship, of substance abuse and mental health. The current consensus is that alcoholism and other forms of substance abuse are not necessarily related to mental health problems. For example, one expert has suggested: "A suitable interim position would be to consider both psychiatric disorders and alcohol and drug problems as independent phenomena which may or may not occur together in the same individual.

Such a position postulates that, in most instances, individuals with psychiatric disorders do not have alcohol and drug problems, and that individuals with alcohol and drug problems do not always have psychiatric disorders. As a corollary, however, it would also postulate that both phenomena may occur together in certain individuals; that is, that there is an area of overlap between the two kinds of problems".(1)

Others put the case for the relationship more strongly arguing that it may well come to pass that there are a number of valid alcoholism models and that only a portion of these are mental health-related in terms of genesis. However, because of the psychological consequences of prolonged drinking, all alcoholism models will ultimately interface to some extent with the field of emotional adjustment.

The important concern is not so much with the nature of the relationship between the two phenomena as with the recognition that mental health and alcohol and drug abuse treatment services occupy overlapping territories.

During the 1960s the Addiction Research Foundation was the major provider of addiction treatment services in the province. Between 1969 and 1975, the Ontario alcoholism treatment network changed from a limited service capability dominated by ARF to a large group of highly diverse, poorly co-ordinated and little understood services (Rush and Brook, 1981:2). Following the Marshman Report (Task Force on Treatment Services for Alcoholics, 1978), the ARF shifted its focus from direct treatment to a treatment service development model which emphasized client assessment centres based in the community and using existing community agency resources.

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(1) Correspondence from Dr. F.B. Glaser, Head of Psychiatry, Addiction Research Foundation Clinical Institute.

One of the major purposes of this shift by ARF was to move away from hospital inpatient treatment to an approach which encouraged treatment on an outpatient or day care basis. According to ARF, this shift was dictated by two major findings of the Marshman Report. The first was that there was no evidence that expensive or sophisticated hospital-based treatment was more successful than community-based treatment. The second finding was that the characteristics of the individual patient, and his or her degree of deterioration, were more important influences on program outcomes than was the nature of the treatment modality itself.

Current ARF plans call for the establishment of 35 community-based alcohol and drug treatment systems. Each system is to consist of four major components: assessment and referral, outpatient counselling, primary care and followup (or case management). Provision is also to be made for alternative living arrangements such as detoxification units and recovery homes. Each of these components is to be provided by existing community agencies which will expand or revise their role to accommodate the specific component. ARF's role is to develop community models, educate, facilitate, train and provide consultation to these agencies.

Hospitals still continue to play a major role in the treatment of alcohol and drug abuse as Table III-19 illustrates. Four of the PPHs have specialized inpatient or outpatient alcohol and/or drug programs - Brockville, Lakehead, Penetang and St. Thomas. Also, North Bay has some addictions beds set aside in a sub-acute unit. Kingston PPH and some others provide alcohol and drug-related psychiatric services on an outpatient basis. In addition, the ARF's Clinical Institute with approximately 63 beds operates as a teaching and research hospital with close ties to the Toronto General and Toronto Western Hospitals.

Table III-19

Status of Ontario Psychiatric Facilities and Provision of Alcohol- and Drug-Related Services: 1979-1980

	Total Number	Alcohol Specific Programs
Provincial Psychiatric Institutions	10	7
Psychiatry Departments in Public Hospitals	59	19
Other Facilities*	4	3
TOTAL	73	29

* Includes the Clark Institute of Psychiatry, the ARF Clinical Institute, The Donwood Institute and the National Defence Medical Centre.

Source: ARF data obtained from a 1980 provincial survey.

Table III-20 provides evidence of the important role still played by hospitals in the provision of alcohol/drug treatment services. Almost 16 per cent of the PPH's and GHPU's caseloads consist of alcohol/drug cases, as do 20 per cent of the caseloads of the other hospitals.(1) More than half of all these alcohol/drug cases are treated by the GHPUs. According to this 1979/80 data, of the 19 GHPUs identified as having alcohol/drug programs, all had outpatient programs and five had inpatient programs.

As of September 1983, the Community Mental Health Services Program had funded 29 programs which provided some combination of assessment, treatment, counselling and referral services to persons with alcohol/drug dependency problems. These programs offer either residential or non-residential treatment services. In addition, CMHS funds 16 detoxification centres across the province which operate as satellite departments of hospitals. These centres provide short-term accommodation and care while the individual is detoxifying, and also link the client to appropriate treatment and support services.

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(1) These figures likely underrepresent the actual incidence, because they do not reflect the number of cases in which the presenting problem - for example, a broken leg - is the result of alcohol/drug abuse.

Table III-20

Extent of Psychiatric Service Involvement in Alcohol/Drug Treatment: 1979/80

Type of Resource	# of Respondents	Estimated % of Caseload	Estimated # of Cases	% Distribution of Total Alcohol/Drug Cases
Psychiatric Units in General Hospitals (N=59)	41	15.9	9,342	57.5
Provincial Psychiatric Hospitals (9) and Other Community-based Residential Facilities (7) (N=16)	9	15.5	3,671	22.6
Community Mental Health Programs (N=26)	23	20.1	3,232	19.9
TOTAL (N=101)	73	16.1	16,245	100.0

Source: Rush and Brook, 1981:32

In addition, MCSS funds 29 halfway houses which are specifically targetted to persons with alcohol/drug problems. Some of these houses have programs run by Alcoholics Anonymous. MCSS is also involved with hostel accommodation through the provision of General Welfare Assistance funds to municipalities.

These developments over the past two or three years represent a major reorganization and expansion of alcohol and drug treatment programs and support services across the province. Some of the problems noted by the Marshman Report in 1978 included the lack of non-hospital assessment and treatment facilities and a closed referral network with little movement of clients across system components. It is too early to determine the extent to which this reorganization and expansion will resolve these problems.

Another factor that mitigates against a more desirable and cost efficient use of the various professional disciplines has been the inadequate supply of government-funded community programs. Individuals who require assistance for a substance abuse problem have the choice of remaining with a physician whose service is covered by OHIP, wait to be seen by a funded program, or, if they are able to afford it, seek out a private practice non-physician professional. The tendency, of course, is for the patient or client to prefer to remain with the prepaid but higher cost professional.

3.5 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Services to children are a critical component of any mental health care system. The prevention, early identification and treatment of the biological or behavioural problems which may lead to psychiatric problems are less expensive in the long term than the direct and indirect costs to society of not providing such services. Effective treatment programs for children have the potential to reduce the number of adults who require mental health treatment services.

Many mental illnesses which develop in the formative years do not disappear with the attainment of adulthood. Studies (Hellon and Solomon, 1980 and Solomon and Hellon, 1980) suggest, for example, that cohorts demonstrating a high suicide risk in their youth continue to present a high risk over their lifetime. Data on age-specific suicides for five-year age groups demonstrate that a depressive or suicide experience in adolescent years is reflected in a continuing high or even higher suicide rate in later life. Thus, assistance and skills directed toward the lessening of depression and suicidal intentions during the adolescent years can be presumed to be of long-lasting benefit (Draft Working Paper submitted to Health and Welfare Canada's Task Force on Suicide, 1983). Robins' (1966) longitudinal study also indicated that children with behavioural disorders tend to become adult personality disorders if intervention is not provided during their childhood.

It is difficult to pinpoint the incidence and prevalance of mental disease and disability among children and adolescents. Surveys may appear confusing or contradictory. The populations studied, the definitions used and the survey methods employed differ widely. Cross-sectional studies which identify all children in a particular population who meet a specified definition of mental health problems at a point in time yield different estimates from longitudinal studies that monitor a more limited group of children over a period of many years.(1)

Consensus regarding definitions of mental health or disease and precise boundaries between "normal" and "abnormal" seems impossible to achieve. Some "illnesses" or "emotional reactions" require professional intervention because of their nature, severity or duration; others do not. By any index, however, a significant minority of most of the Western world's child and adolescent population suffers from a psychiatric disease or disability. In 1969, the U.S. Joint Commission on the Mental Health of Children estimated that 10 per cent of children were in need of some form of mental health assistance. In 1978, the President's Commission on Mental Health placed the figure at approximately 15 per cent. In 1981, a published review of 31 studies concluded, after allowing for varying methodological and definitional differences, that the prevalence of clinical maladjustment among children in the United States was probably at least 11.8 percent. (A Project of the American Academy of Child Psychiatry, 1983:38).

A wide range of psychiatric problems affect children and adolescents. Some of these disturbances are unique to childhood or adolescence, while others are similar to disturbances seen in adults. A review of 441,429 children and adolescents admitted in 1975 to selected private psychiatric hospitals, state and county mental hospitals, general hospitals and psychiatric out-patient services in the United States, indicated a range of disturbances. Tables III-21 and III-22 show the diagnoses (DSM-II) for child and adolescent inpatients and outpatients (ibid.:42).

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(1) The results of the Ontario Child Health Survey of 4,000 children ages 4 to 16 are being analyzed by Dr. Dan Offord of McMaster University. One of the aims of the study is to obtain unbiased and precise estimates of the prevalence of four disorders - conduct disorder, attention deficit disorder, somatization and neurosis - in children in Ontario.

Table III-21

DSM-II* Diagnoses for 441,429 Children and Adolescents Admitted to Inpatient Services in 1975

Diagnosis	Percentage of Subjects
Adjustment Reactions	30%
Schizophrenia	17
Behavior Disorders	13
Depressive Disorders	13
Personality Disorders	9
Neuroses	5
Alcohol and Drug Abuse	4
Mental Retardation	2
Other Diagnoses	7

* Diagnostic and Statistical Manual of Mental Disorders.

Source: A Project of the American Academy of Child Psychiatry, 1983:38.

Table III-22

DSM-II* Diagnoses for 441,429 Children and Adolescents Admitted to Outpatient Services in 1975

Diagnosis	Percentage of Subjects
Adjustment Reactions	45%
Behavior Disorders	15
Personality Disorders	4
Mental Retardation	4
Schizophrenia	2
Depressive Disorders	2
Neuroses	2
Other Diagnoses	26

* Diagnostic and Statistical Manual of Mental Disorders.

Source: A Project of the American Academy of Child Psychiatry, 1983:38.

Children's mental health services in Ontario were the responsibility of the Children's Mental Health Branch of the Ministry of Health until July 1977, at which time that responsibility was transferred to a newly-established Children's Services Division in the Ministry of Community and Social Services to facilitate an integration of all government programs for children with special needs.

The enthusiastic expansion of programs of the previous two decades had resulted in considerable progress in some aspects of child care, and most children and families had access to some services. However, the period of expansion had also produced by the early 1970s a disorganized, fragmented, sometimes duplicative and certainly unmanageable system. While many examples of inter-agency co-operation and the matching of services to the unique needs of the child could be found, several incidents occurred which also demonstrated that gaps in service and lack of co- ordination were by-products of a large, but disorganized, system of children's services (Ontario Ministry of Community and Social Services, 1980a:9).

While the majority of children's mental health services are now provided by the Ministry of Community and Social Services, a number of services are funded and monitored either jointly by both Ministries or independently by the Ministry of Health (Chart III-7).

Eight of MCSS's 73 Children's Mental Health Centres have been developed as regional resources which provide specialized psychiatric diagnoses, assessment and treatment services and back-up to the other centres. All 73 Children's Mental Health Centres receive 100 per cent funding for all approved operating costs under the Children's Mental Health Services Act (1978). The report of a survey done by the Ontario Association of Children's Mental Health Centres, to which 71 per cent of the Centres responded, indicated that, as of March 31, 1982, 10 per cent of the children they served were receiving residential treatment. The remainder were involved in outpatient, day treatment or home care programs.

Chart III-7

Mental Health Services for Children Funded by the Government of Ontario: 1982

Funded and/or Licensed by Ministry of Community and Social Services (MCSS)	Funded by MCSS & MoH	Funded by Ministry of Health
73 Children's Mental Health Centres	4 CMHC's share staff and facilities with hospitals	19 Outpatient Children's Mental Health Clinics in Public General Hospitals
		4 Child and/or Adolescent Inpatient Units**
	3 joint satellite community mental health clinics	
	1 CMHC joint undertaking with an adult community mental health clinic*	
	1 CMHC joint undertaking with an adult community mental health clinic is currently being formed	
	4 Child and Adolescent Units in Provincial Psychiatric Hospitals	

* Part of 73 incorporated Children's Mental Health Centres.

** In August 1983, the Ministry of Health funded a six-bed child and adolescent crisis intervention unit at the War Memorial Children's Hospital in London.

Source: Ontario Ministry of Community and Social Services, 1982.

Numerous other agencies and institutions which comprise part of the network of children's services may provide mental health services to children as well (Chart III-8).

Chart III-8

Agencies Which Provide Mental Health Services for Children: 1982

Funded and/or Licensed by Ministry of Community and Social Services (MCSS)	**Funded by Ministry of Health (MoH)**
51 Children's Aid Societies (with residential capability)	
67 Probation and Aftercare Offices (36 with residential capability)	
Children's Residential Services to include:	
63 Children's & Youth Institutions	190 Public General Acute Hospitals of which 164 have Paediatric Services and 60 have Psychiatric Services (designated Schedule I facilities under the Mental Health Act)
26 Observation and Detention Homes	43 Public Health Units
186 Group Homes (plus 120 extensions)	145 Adult Community Mental Health Programs (approximately 53 are clinics)
7 Training Schools	
18 Correctional Group Homes	
23 Facilities for Mentally Retarded of which 10 serve children only and 13 serve children and adults.	

Source: Ontario Ministry of Community and Social Services, 1982.

In December 1980, an Interministry Committee on Children's Mental Health Services, with representation from the two Ministries, was established at the direction of cabinet to, among other things, clarify the roles of the two Ministries. A field study was undertaken and the results were discussed in a report submitted to the Interministry Committee in September 1982. The study indicated that, while many children were being served well by the current arrangement of co-ordinated services, there were groups of children for whom mental health service was not available by either one or the other Ministry or through the co-operative efforts of both. More specifically, the problems identified in the report were as follows (Ontario MCSS, 1982).

1. There are some adolescents with mental health problems who remain at risk because frequently they are beyond the age of eligibility for MCSS facilities yet below the age for MoH adult services;

2. There are some multiple handicapped disturbed youngsters who remain at risk because the many special services required to serve them cannot be co-ordinated;

3. Emergency or crisis services are not consistently available for a child with mental illness and there is a need for common understanding of the appropriate uses of such services;

4. Some children are being discharged following suicide attempts without adequate aftercare services in place;

5. There are some children requiring residential treatment who, because of the severity of their illness, cannot be treated by an MCSS facility but who, because of age and behaviour, cannot be maintained in a hospital;

These problems were underlined in my discussions with children's mental health care providers. A number of other concerns were also expressed. One of these is the inability of Children's Mental Health Centres as they are currently funded to meet the level of service demand. An Ontario Association of Children's Mental Health Centres survey indicated that as of March 1982, more than 1,000 children were on the waiting lists of the member centres.

Seriously troubled children require intensive treatment by teams of highly trained staff. The costs of children's mental health residential and out-patient services are comparable to hospital and other health care costs. In the opinion of many providers, the transfer of Children's Mental Health Centres to the Ministry of Community and Social Services has resulted in pressure to reduce these costs because they are higher in comparison with costs in the general field of social welfare services.

A second important area of concern has to do with the perception that MCSS is placing insufficient emphasis upon providing treatment services to children. This perception derives from MCSS's philosophy which emphasizes a "care" model rather than a "treatment" model. I suppose my own biases are obvious on this issue. Practically speaking, however, the critical issue is not which model is better. The balance between care and treatment will vary from child to child and, from time to time for each individual child. If that principle is accepted, then the concern is solely to ensure that those children, whatever their number or degree of illness, receive the proper mix.

A definition of "treatment" vis-a-vis children has been developed recently by the Board of Directors of the Ontario Association of Children's Mental Health Centres and is being considered by the membership. It is a definition which is entirely sensible:

> "Treatment can be defined as a planned systematic intervention, or set of interventions, based upon a diagnostic formulation related to some identifiable theory of development and deviation employing an identifiable methodology and aiming to achieve specified change objects. The notions of

> 1. systematic planning
> 2. diagnostic formulation
> 3. a developmental theory, or synthesis of theories
> 4. a theory or theories of deviation
> 5. application of specific methodology
> 6. setting of specific change objectives
>
> are all necessary conditions to satisfy this definition of treatment."

One consequence of the MCSS's emphasis upon the care model is that it is becoming difficult to attract medical staff interested in providing treatment for psychiatrically disturbed children and adolescents in MCSS-funded mental health facilities.

In addition, my discussions with various providers of children's mental health services in both ministries has indicated that the two ministries have not succeeded in co-ordinating their complementary services at the delivery level. Both ministries are aware of this problem and are examining possible mechanisms for joint planning, co-ordination of services and joint funding at the local level.

The recently proposed legislation, The Children's Act, which would bring together under one Act all legislation related to MCSS children's programs, has served only to heighten the concerns noted above. The MCSS consultation paper in which the Act is discussed has generated a great deal of debate. There is no mention of our obligation to provide the child with treatment when it is required; rather the emphasis seems to be on "protecting" the child from treatment. The proposed right of the child to refuse treatment when the doctor and family consider it necessary does not give sufficient consideration to the probability that the child may not be aware of the consequences of refusing treatment; nor does it give sufficient consideration to the fact that the parents continue to be legally responsible for the child. The tenor of the consultation paper is "rights" oriented and, consequently, introduces a legal and inevitably adversarial procedure into the decision regarding appropriate treatment. The notion of the "least restrictive alternative" should, at best, be seen as a qualifier to our obligation to provide the child with treatment when it is deemed necessary. The overriding principle should be that each child have access to that service most likely to result in the most positive benefit for that child.

The proposed Act is in the process of being revised by MCSS prior to submission to the Legislature. I understand that in the course of this revision MCSS will accommodate these concerns.

Another important issue related to children's mental health services is the Ministry of Community and Social Services' attempt to obtain cost-sharing with the federal government under the Canada Assistance Plan. Cost-sharing under this plan can be obtained only if it can be shown that the services provided are not health services and that there are no treatment components to them. I believe that MCSS recognizes that treatment programs should not be compromised in order to qualify for cost-sharing programs. The difficulty lies in distinguishing those children's services which do not include treatment, and therefore will be eligible for CAP funding, from those which do, and, in the process, avoiding compromising existing and required treatment services.

Another concern relates to the small number of child psychiatrists being trained. There are only a few residency slots in children's mental health facilities. The salaries for residents in some MCSS-funded facilities are not keeping pace with resident salaries in MoH-funded facilities. Job satisfaction is also more difficult for psychiatrists to achieve because of the greater emphasis on care rather than treatment espoused by many of the other professionals working in children's mental health facilities and because they are isolated from most of the medical peers who relate to a different Ministry. Consequently, too few psychiatrists are being attracted to this sub-specialty.

In addition, there is no OHIP provision for psychiatrists to consult with agencies, (for example, school boards and Children's Aid Societies), other than for case conferencing in relation to a specific patient. As sessional fees are in short supply, there is limited provision for consultation with other professionals. Thus, child psychiatrists, except when salaried, tend to do more direct treatment than consultation, which seems to be an inefficient use of a very scarce resource.

In general, I found among mental health professionals a very genuine and increasing concern regarding treatment services for children. There is also a consensus that the single, most critical gap in all children's mental health services is for young persons between the ages of 16 and 19, the years during which the most serious of mental illnesses, for example schizophrenia, often manifests itself and takes firm hold. This problem is an almost inevitable result of a division of responsibility between two Ministries which is based on age and not on function. The problem of how to connect the children's and adult service systems to provide continuity of care for the seriously mentally ill adolescent must be resolved.

4.0 REHABILITATION AND MAINTENANCE

4.1 INTRODUCTION

The primary tasks of psychiatric rehabilitation are: (1) to assist in re-integrating psychiatrically disabled persons into the community; and (2) to maintain and increase their ability to function independently, (Anthony et al, 1978:365). The objective of rehabilitation services should be to provide the psychiatrically disabled person with the physical, intellectual and emotional skills needed to live, learn and work in the community with the least possible amount of support from the helping professions (Anthony, 1977:660). The emphasis in psychiatric rehabilitation is upon skills development and not upon symptom remission.

Maintenance refers to those activities aimed at maintaining the individual at his or her fullest potential and/or preventing the individual's condition or level of functioning from deteriorating (Cohen, 1982). Many of the services provided in a maintenance program are similar to those in a rehabilitation program. The major difference between the two types of programs is not the programs themselves but the ends towards which the programs are used: encouraging the individual to independent functioning or maintaining the individual who cannot be independent with the type and level of support necessary to prevent deterioration.

In this report the term "rehabilitation and maintenance" are considered to be synonymous with what sometimes are described as "community support services".(1)

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(1) Another term often used is "aftercare". I take that to mean on-going care of the individual after discharge from a hospital or other treatment program. The term connotes the therapeutic component.

There are two groups, including both ex-psychiatric hospital and non-hospital mental health patients, who need mental health rehabilitation and maintenance services in the community. The first group consists of those who suffer from a mental or emotional disorder that sharply limits the ability of the individual to interact with his or her environment in such a way as to sustain oneself adequately and/or relate competently to others (CMHA, 1982:18). The usual estimate is that at any given time between 0.35 per cent and 1 per cent of the total population suffer from a chronic and disabling mental disorder which necessitates continuing care. This would include many sufferers of schizophrenia and affective disorders (Bland, 1982; Goldman 1981; CMHA, 1982). For some number of people in this group, the potential for rehabilitation is limited and, consequently, the emphasis for this group is necessarily upon maintenance services, most particularly a place to live and an activity program.

In the absence of appropriate rehabilitation and maintenance services, this group will generate higher rates of hospital readmissions. This is one of the economic implications of inadequate rehabilitation and maintenance services. The human cost is difficult to measure, but a survey of their membership by the Metropolitan Toronto Branch of Ontario Friends of Schizophrenics (1983) found that, over a four-year period, there had been 21 suicides, all of whom were not involved in any rehabilitation program, were not taking their prescribed medication and were alone at the time. Another dimension of the human cost is that, as one recent study found (Turner and Avison, 1983), at least 25 per cent of the families and people intimately associated with discharged psychiatric hospital patients suffer serious mental distress themselves as a result of the mentally ill person's constant presence in the home.

The second group consists of those who require access to some rehabilitation services, usually on a short-term basis, while they are in the process of reintegrating themselves back into their normal lives. Most, or many, of these people have a one-time episode of mental illness. They are not the major users of rehabilitation services. Their need for rehabilitation services is usually limited and of a transitional nature.

The following discussion of rehabilitation and maintenance services concentrates upon the first group of users, those with substantially reduced competencies attendant upon a mental illness.

The essential components of rehabilitation and maintenance services are deemed to include:

- Accommodation: a place to live;
- Vocational and educational services;
- Social and recreational services;
- Life skills training, including financial management.

In its 1982 report on the national situation, the CMHA identified the following rehabilitation and maintenance services to be the least available or most in need of improvement: housing, sheltered occupational opportunities, social and recreational outlets, aftercare and followup services. These are, of course, the services most required by all groups suffering from some form of disability, either physical, mental or financial. It might be noted that the tendency for available services to be located in the major urban centres encourages those requiring these services to locate in these major centres, effectively relieving their home municipalities of any financial or other responsibility for their welfare.

There are approximately 42 rehabilitation programs funded by the Community Mental Health Services Program. These programs are delivered by various agencies and organizations, often by local branches of the Canadian Mental Health Association. The range of services offered by these various programs, and likely the quality of services, varies considerably. Some programs have only a part-time or full-time coordinator and are heavily dependent upon volunteers; others have six or more staff on a full- time basis. Some programs include recreation and fitness in their activities; some include industrial workshops and job skills training; some are directed towards a particular ethnic group or type of illness such as schizophrenia; some programs are directed towards residents of nursing homes; some are a part of an integrated hospital/community rehabilitation program; some programs are open only on a part-time basis; some operate only a volunteer driver service.

In 1979, the Ontario Council of Health's Task Force on Maintenance and Rehabilitation concluded (1979:11) that "clearly, the maintenance and rehabilitation resources, the community support systems and case management services for the mentally ill are totally inadequate". Since 1979, however, the Community Mental Health Services Program has funded increased numbers of programs. Charts III-2.2 and III-2.3 (see pp.47 and 48) indicate the substantial growth in the number of these programs from 1982/83 to 1983/84 and an improved distribution across the province. The distinction between treatment on the one hand and rehabilitation and maintenance on the other among these CMHS-funded programs is not easily established because some programs do both. But, if one looks at housing and rehabilitation programs, one can see an improvement in their numbers and distribution. They are still, however, far from adequate, particularly for specific target populations, such as young assaultive schizophrenics and psychogeriatrics.

Even when services do exist, there is evidence that at least some hospitals have a low rate of patient referral to non-treatment community support services such as social, recreation and vocational rehabilitation (CRC, 1981:22).

Before entering into a review of rehabilitation and maintenance services specifically, the subject of income maintenance should be discussed. A recent study of ex-patients from London Psychiatric Hospital found that one-third of the sample had household incomes that placed them below the poverty line as determined by Statistics Canada (Turner and Avison, 1983). The discussion in the next section concerning accommodation suggests that these figures are fairly representative of ex-PPH patients generally.

The issue of income maintenance is a serious one for mentally ill persons who, regardless of whether they have ever been in a psychiatric facility, are unable to sustain themselves at a reasonable financial level because of reduced competency. The most recent estimates are that, in the month of April 1982, individuals in receipt of Family Benefits Allowances for medical reasons and with a primary diagnosis of psychiatric illness totalled about 8,800. This constitutes about 15 per cent of some 60,000 people on FBA for medical reasons (MCSS, September 1983).

The standard procedure is for the individual to make application to the municipal social services department.(1) The department decides whether the individual will receive General Welfare Assistance, which is short term and the lowest level of assistance, or might be eligible for Family Benefits Allowance, in which case the application is forwarded on to a regional office of MCSS. One of the complaints I have had is that applications for assistance by the psychiatrically disabled are being designated by municipal social services departments for General Welfare Assistance instead of being considered for FBA. MCSS, as a participant in the Interministry Committee on Housing and Support Services for Ex-Psychiatric Patients, recently expedited a review of long-term GWA recipients vis-a-vis their eligibility for FBA. The outcome was that a higher proportion of applications were deemed eligible for FBA, suggesting that there may be some merit to this complaint.

If the application is forwarded on to MCSS, a Medical Advisory Board reviews the application and decides whether the applicant is disabled or permanently unemployable, in which case the applicant qualifies for FBA. Even when the individual is eligible for FBA, the level of financial assistance provided imposes constraints upon the individual. If the individual is living in non-profit accommodation, the allowance is $364 a month; if the individual is living in market housing, the allowance is $382 or about $4,600 a year. People may also qualify for a shelter subsidy, and they also receive free medical and hospital insurance, basic dental care and prescription drugs. It should be noted that the Statistics Canada definition of "poverty line" for a single person living in the country is $7,052 and is higher for single persons living in the city. It appears, therefore, that neither level of assistance is adequate.(1)

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(1) There has been a suggestion that PPH patients cannot make application for FBA until they have been discharged and have a permanent address. The regulations indicate, however, that an individual can make application for FBA prior to discharge, and can also obtain a discharge benefit to assist in establishing his or her residence in the community upon discharge from an approved institution which include PPHs but not GHPUs.

The following pages deal first with accommodation and then with the other rehabilitation and maintenance services.

4.2 ACCOMMODATION: A PLACE TO LIVE

Perhaps the most important single component of rehabilitation and maintenance services is accommodation. Appropriate accommodation can do a great deal to enhance the client's transition to fully independent living or, at a minimum, reduce the likelihood of readmission to the hospital and provide a better life. For example, a recent four-province follow-up of schizophrenic patients living in the community (Wattie, 1983) found that one characteristic which promotes improved functional outcomes for these patients is an appropriate place to live in the community.

This need for non-hospital accommodation has been apparent for some time, and in the 1960s the Ministry of Health began to place increasing emphasis upon non-hospital residential alternatives for psychiatric patients. The Homes for Special Care Program was introduced in 1964 as part of the provincial psychiatric hospitals program. Beginning in 1976, the MoH began to fund community housing programs in increasing numbers for both ex-psychiatric hospital and non-hospital clients through the Adult Community Mental Health Program (now Community Mental Health Services Program).

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(1) Social assistance rates were increased five per cent in October 1982 and five per cent in November 1983 (The Globe and Mail, November 9, 1983:8).

Nonetheless, the available stock of appropriate accommodation is still inadequate and a source of pressing concern. One study in Metro Toronto (Community Resources Consultants, 1981) found that 35 per cent of patients discharged in the preceding six months were living in a room, boarding home or transitional residence, 20 per cent were living in conditions which were inadequate, and 40 per cent were dissatisfied with the place in which they lived. A more recent study restricted to a functionally psychotic population in the London area came to similar conclusions: "...while a clear majority of ex-patients lived in quite satisfactory circumstances, a significant minority was found in substandard housing and some of the ex-patients appeared to experience substantial residential instability" (Turner and Avison, 1983).

There are also strong indications that the type of housing stock most suited to the mental health client group is shrinking and becoming more expensive, particularly in the downtown or older areas of urban centres, as land values increase and properties are upgraded or replaced.(1) Apartment vacancy rates in the major urban centres have declined to between one and two per cent, indicating very little is available. Housing in the core urban areas is often too expensive for the mentally ill person or the sponsor, and is often protected by municipal zoning bylaws which preclude non-family congregate living. One of two things happen. The less advantaged proportion of the population - including many mental health clients - are forced into housing in areas where mental health, social, and other services, including transportation, are scarce, thereby increasing the likelihood of a relapse and the need for readmission to a psychiatric facility. Or, they congregate in an area, such as Parkdale in Toronto, where municipal bylaws for some years allowed non-family residential, with the result that local support services become overloaded.

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(1) See 1) Ontario Ministry of Health Task Force Report on Homes for Special Care (1976); 2) Ontario Council of Health, Agenda for Action (1979); 3) Ontario Council of Health, Task Force on Maintenance and Rehabilitation Report (1979); 4) Canadian Mental Health Association (1981a); 5) The Municipality of Metropolitan Toronto, Social Services Department, (1979); 6) Community Resources Consultants of Toronto (1981); 6) Medicus Canada (1982).

Consequently, any discussion of accommodation for the mental health client must acknowledge at the outset that we are dealing with a scarce, often expensive, commodity which is extremely difficult to control and which is sometimes deliberately 'protected' from citizens who need non-family residential accommodation.

The following is a review of the significant providers of accommodation services for the mental health client. It should be emphasized at the outset that the provision of non-institutional accommodation is only the first, albeit perhaps the most important, component of an effective rehabilitation and maintenance program. If accommodation is considered the entire rehabilitation program, then the client simply becomes dependent upon a different support system; the client has not been taught (life skills training, vocational rehabilitation, etc.) to be any more capable, productive or independent than he or she was as an inpatient (Anthony, 1977:660). Therefore, other rehabilitation and maintenance programs must be provided in conjunction with appropriate accommodation.

4.2.1 Ministry of Health

4.2.1.1 Homes for Special Care Program:

The HSC Program was introduced in 1964 under the Homes for Special Care Act to fund accommodation for those persons who, on discharge from provincial psychiatric hospitals or regional centers for the retarded, required supervised community living arrangements. This discussion deals only with those persons discharged from the PPHs.

At the time the HSC Program was established there was a large number of patients in the PPHs who had been there some considerable period and were absorbing substantial PPH resources, but who did not need the full resources of the PPH. It was thought that the establishment of the HSC Program would remove these patients to appropriate but less expensive settings and free more PPH resources.

The HSC Program, as originally conceived, was intended to provide care which would cover the spectrum from simply supervision to medical/nursing care below psychiatric hospital level. It was considered at that time, however, that residents discharged to HSCs did not require or could not benefit from active rehabilitation services.

There are two categories of homes which fall within the HSC Program: nursing homes and residential homes. Nursing home beds were intended to be used by those ex-PPH patients who required part-time nursing care on a daily basis; Residential homes were designated for those ex-PPH patients who could not, as yet, be classified as self-sufficient in the community and who required in the interim a supervised environment, but not nursing care. Both nursing homes and residential homes are privately operated facilities.

Nursing Homes:

(1) Extended Care. This service involves skilled nursing and personal care given by or under the supervision of a registered nurse or registered nursing assistant under the direction of a physician to a resident of the nursing home for a minimum of 90 minutes per day.

(2) Intermediate Care. This involves nursing and personal care given by or under the supervision of a registered nurse or registered nursing assistant under the direction of a physician to a resident of the nursing home for less than 90 minutes per day.

Guidelines and staffing patterns for nursing homes are stipulated in the Nursing Homes Act and Regulations.

Residential Homes:

These homes provide non-nursing care and supervision in a family-like setting. There are no guidelines or staffing standards established for residential homes (Ontario Ministry of Health, 1981b:8).

Each PPH is responsible for those of its ex-patients who are accommodated in a home under the HSC Program. Conversely, individuals can enter a nursing or other home under the HSC Program only if he or she is a PPH inpatient. The number of HSC Program residents in nursing homes increased dramatically from 1965 to 1971 then began to drop. The number of HSC Program residents in residential homes also increased substantially in the few years after 1965 and since then has shown modest annual increases. Table III-23 indicates the rate of growth in both nursing and residential homes. Included in these figures are both ex-psychiatric (MoH) and mentally retarded (MCSS) residents. Typically, ex-psychiatric clients constitute about two-thirds of the total resident population (Ernst and Whinney, 1982). Table III-24 indicates the number of HSC nursing and residential homes attached to each PPH.

Table III-23

Residents in the Homes for Special Care Program: 1965-83

	Year	Number of Occupied Beds
Nursing Homes	1965	1,621
	1970	5,651
	1981	4,664
	1983 (July)	4,364
Residential Homes	1965	47
	1970	1,502
	1981	2,078
	1983 (July)	2,170

Note: Includes both ex-provincial psychiatric hospital patients and mentally retarded residents.

Source: MoH, Mental Health Division, September 1983.

Table III-24

Homes for Special Care - Nursing and Residential Homes: July 1983

	Nursing Homes		Residential Homes		
	# of Homes	# of Occupied Beds	# of Homes	# of Occupied Beds	Total # of Occupied Beds
Brockville Psychiatric Hospital	21	401	17	172	573
Hamilton Psychiatric Hospital	21	242	31	207	449
Kingston Psychiatric Hospital	25	442	39	130	572
Lakehead Psychiatric Hospital	3	146	20	54	200
London Psychiatric Hospital	40	920	23	249	1169
North Bay Psychiatric Hospital	16	392	32	147	539
Owen Sound General and Marine Hospital	11	198	11	51	249
Penetanguishene Mental Health Centre	13	382	36	177	559
Toronto (Queen Street Mental Health Centre)	29	577	41	629	1206
St. Thomas Psychiatric Hospital	19	178	20	163	341
Whitby Psychiatric Hospital	18	476	27	191	667
TOTAL	216	4,364	297	2,170	6,534

Note: Includes both ex-provincial psychiatric hospital patients and mentally retarded residents.

Source: MoH, Mental Health Division.

A recent study (Ontario Ministry of Health, 1981b:27) indicated that 93 per cent of the HSC Program residents were placed there because they needed continuing supervision, and 88 per cent were considered appropriately placed. Of the 12 per cent who were inappropriately placed, 10 per cent were categorized as without psychiatric/behaviour problems.(1)

The HSC Program continues to be the major discharge resource for PPH patients who require long-term supervised living arrangements in the community. But there have been problems and the Program has been the subject of continuing concern and review since its inception. In 1976, the Homes for Special Care Task Force was established by the MoH. In 1981, the Program was studied by both a Triministry Project and an MoH Staff Review, and at the time of writing the Ministry has another study underway. Obviously, the field is already well trodden; however, many of the problems remain: "It appears that the existing HSC Program is not fully meeting the needs of patients now being discharged from provincial psychiatric hospitals who require on-going care and twenty-four hour supervision." (Ontario Ministry of Health, 1981b:33). At the same time, I should also emphasize that some ex-PPH patients have benefitted from their transfer under the HSC Program.

The major problems range from resident selection through policy, planning and evaluation. The discharge planning process to HSC beds is not clearly defined nor uniformly developed across all PPHs. The criteria for discharge from PPHs under the HSC Program are not clear, and this option often appears to be taken in the perceived absence of other options. Program objectives and guidelines for program evaluation are not clear and the possible roles of the program - custodial, rehabilitative, social - are not well defined. Where there are criteria for evaluation there is little follow-through. Policies and procedures are out of date, there is no defined consistency between the HSC Program policy and practices and the MoH's thrust in mental health services (Ontario Ministry of Health, 1981b).

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(1) This is consistent with other evidence that a significant number of persons in homes for the aged, nursing homes and chronic care hospitals are unsuitably placed (Cape et al, 1977; data provided by MoH District Health Council Program).

Most of the residential homes have fewer than 10 residents and the operator usually employs no support staff. No particular qualifications are required of the candidate operator for his or her nursing or residential home to be eligible under the HSC Program, and minimal training or orientation is provided except on an ad hoc basis by field staff. Apart from medical histories, the operators receive little information on the ex-patient's social and behavioural history except, again, on an ad hoc basis by the field worker (CMHA/Ontario Division, 1981b).

Part of the original Program concept was that a discharge planning team would be established for each HSC resident, consisting of the individual's family or next of kin, the attending doctor, head nurse and social worker, to determine the best possible placement for the patient. Once discharged to a residential home, each patient was to be supported and visited, and the home was to be carefully monitored, by a field worker from the hospital.

Only 30 HSC field workers from all the PPHs are assigned to the current 297 residential homes and approximately 4,300 HSC psychiatric residents, a large case load. These field workers are responsible to their respective PPHs and work out of the hospitals. The caseload problem is compounded in the north by that of distance. All the HSCs tend to be within a 50 mile radius of their specific provincial psychiatric hospitals; but in northern Ontario the North Bay PPH has homes in Sault Ste. Marie, and the Lakehead PPH has homes in Kenora. An even more important problem is that the role of the field worker is not well defined, and effectiveness depends on the conscientiousness and determination of the individual worker.

In 1974/75 nursing home beds constituted 88 per cent of the total number of HSC beds; by 1980/81 this proportion had fallen to 43 per cent (Ontario Ministry of Health, 1981b:22b). There are several reasons for this reduction. Direct placements are being made by PPH psychogeriatric units to nursing homes rather than through the HSC program. There has been a steady decline in the older chronic PPH population being discharged who require nursing care. The PPHs now have increasing numbers of younger patients with more severe psychiatric problems and more prone to anti-social behaviour.

While these persons often need a supervised residential environment, they do not need nor should they be in a nursing home; and they also often need programs and these are not available under the HSC Program. A number of these younger ex-patients end up in the HSC residential home component. The current per diems are not sufficiently high to provide programs for the residents.

Also, nursing home operators prefer geriatric and psychogeriatric residents under the Extended Care Program who require lower levels of supervision and staffing. The MoH Staff Review in 1981 found the majority of persons being placed in nursing homes under the HSC Program were geriatrics whose medical/nursing needs were paramount. Their psychiatric problems were similiar to those of the other aged residents in nursing homes who had been admitted from public hospitals or directly from the community. For all practical purposes, there was little or no difference in needs of or the care and treatment accorded regular Extended Care residents and HSC nursing home residents.

Nursing home residents tend to be a heterogeneous group. Not only do ex-PPH patients and the mentally retarded fall within the HSC Program, but there are considerable disparities in age as well. It is not uncommon to find the young living together with the old, the retarded with the psychogeriatric and the infirm.

The absence of rehabilitation and maintenance programs for HSC residents is regrettable. The Ministry currently has a study underway on this subject and it is to be hoped that the thrust of that report will be in favour of providing programs to HSC residents.

4.2.1.2 Approved Homes Program

The Approved Homes Program operates under the Mental Hospitals Act and the individual Approved Homes are the responsibility of the respective provincial psychiatric hospitals. The intention is to provide transitional beds in a family or small group setting for persons about to be discharged from PPHs into the community.

The expectation in establishing the Approved Homes Program was that psychiatric patients would find their transition back into the community eased by living in a "normal" setting for some period of time prior to entering a fully independent living environment. The Approved Home placement is regarded as an essential element of therapy. The patient is expected to go to work, school or some appropriate program during the day. Under the program PPH patients are discharged into the Approved Homes usually on a six-month basis (sometimes up to 12 months). At the end of that period, or before then, a joint decision of the PPH social worker, rehabilitation officer and home operator can have the patient sent back to the PPH; otherwise the patient is discharged into the community.

By the mid-1960s, there were 1,500 beds available for ex-psychiatric patients under the Approved Homes Program. Subsequently, the number of Approved Homes began to decline dramatically. As of August 1983, there were only 29 Approved Homes providing 155 licensed beds operated by eight provincial psychiatric hospitals. Of these beds, an average of 98 were occupied.

There are several reasons for the major decline in the program. Many of the Approved Home patients were 'chronic' and more appropriately accommodated, it was thought, in Homes for Special Care beds once these were established. There were also an increasing number of other residential opportunities funded through the Adult Community Mental Health Program which was established in 1976 (now called the Community Mental Health Services Program).

As deinstitutionalization took hold in the PPHs, the characteristics of the PPH population also changed. Inevitably, there was a heavier concentration of socially maladaptive patients, usually younger and more active (or aggressive), and the number of Approved Homes willing to take such patients decreased.

The Ministry also had concerns about the quality of life in many of the homes and the difficulties of maintaining suitable levels of supervision. Apart from the usual health and safety standards, Approved Home operators need meet only minimal requirements. They receive an orientation program from PPH staff and, possibly, some on-going training in nutrition, handling of emergencies, behaviour modification, recreation and the like. The process by which these homes are monitored is inadequate.

4.2.1.3 Community Mental Health Services Program

One of the objectives of Community Mental Health Services is to fund programs in supportive group living arrangements for adults (18 years and older) who are receiving or who have received psychiatric treatment. As of September 1983, 47 out of the 251 CMHS-funded programs involved the provision of such services.

Typical types of housing include transitional housing, co-operative housing and half-way houses. Most of the houses provide residents with accommodation for anywhere from 3 to 12 months while the residents prepare themselves to move into the community mainstream; however, some houses, such as Regeneration House II in Toronto, allow for an indefinite length of stay. The number of residents in a home varies from 3 to 18, but most houses take between three and six residents.

Typically, this accommodation is directed towards the needs of Low Psychiatric/Low Physical mental health clients; that is persons who need little or no medical care apart from, perhaps, out-patient medication, and who can live in a residential setting with some supervision and support. In most cases residents are expected to share in the responsibility for the running of the home. Most of the homes stress the development of self-help skills in a structured or informal program and expect residents to pay their share of the accommodation costs.

Frequently, the housing program is only one component of a more comprehensive set of activities operated by a local agency. With respect to program content, some of the houses - such as Regeneration House III in

Toronto - offer a highly structured environment for chronic ex-psychiatric patients; the North and South Peel Alternative Housing Program in Mississauga requires that residents be involved in a day program of some kind (school, workshop, mental health clinic or full- or part-time employment).

The largest of the community-based alternative housing programs funded by CMHS is Houselink Community Homes Inc. in Metropolitan Toronto. It operates 12 co-operative, co-educational housing units for three to five persons each. Residents pay their own rent and are largely independent, but receive support from volunteer house co-ordinators and Houselink staff.

As Chart III-2.3 illustrates, the distribution of the 47 housing programs across the province is still uneven. There is only one program in each of the two northern regions. It seems likely that parts of other regions are also still experiencing a shortage of such accommodation. Were such accommodation available, it is likely that - extrapolating from our earlier analysis of the three PPHs - perhaps 980 Low Psychiatric/Low Physical PPH patients could transfer into community living arrangements. To this number one should add those individuals in the HSC Program who are inappropriately placed.

4.2.1.4 Home Care Program

This program was established by the Ministry of Health in 1968. By 1974, 38 acute home care programs were being operated across the province, the majority (30) of them by Health Units, the remainder by local Victoria Order of Nurses branches (4), local general hospitals (3), and one by an independent incorporated board in Metropolitan Toronto.

Home care programs are intended to provide medical, social and related services to individuals in their homes. On a medical referral, any Ontario resident covered by OHIP is eligible for Home Care, providing the appropriate recommended service needs cannot be met on an out-patient basis. Home Care staff can, for example, arrange for visits by a registered nurse, for regular treatment by a physiotherapist or occupational therapist, for social work services, for nutritional counselling and for drugs.

The exclusive focus in the early years of the Program was on acute care services. Beginning in the mid-1970s, the Program began to make services available to chronic patients. Currently, the program has expanded to provide services to chronic patients across the province, except in Metropolitan Toronto. Specific eligibility criteria in the acute program include the expectation that the patient's professional treatment program is reasonably expected to result in patient progress toward established rehabilitation goals. To be eligible for chronic home care, the patient must be in medical need of at least three visits per month by professionals and his or her treatment program is reasonably expected to result in progress toward established rehabilitation goals, or the delay/prevention of deterioration in the patient's medical condition, or the delay/prevention of transfer to a higher (institutional) mode of care.

The Program has grown rapidly. A total of 103,003 persons were admitted to the Home Care Program in 1981-82 : approximately 84 per cent of these persons were admitted to the acute care component of the Program. Approximately five per cent of those admitted during 1982 had either a primary or secondary psychiatric diagnosis, including senile and pre-senile dementia, alcoholic psychosis, psychosis, and non-psychotic mental disorders but, excluding alcoholism, drug dependence and mental retardation (MoH, Home Care Program).

The flexibility of this program and its setting in the accustomed surroundings of the client guarantee that the demand for it will continue to increase.

4.2.2 Ministry of Community & Social Services

Under the General Welfare Assistance Act administered by MCSS, some municipalities contract with commercial hostel operators to provide domiciliary hostel accommodation for disadvantaged persons. One of these hostels can accommodate up to 150 persons. Although this type of accommodation was originally intended to provide short-term accommodation for needy persons, it has become increasingly used as long-term accommodation for persons with special needs (A.M.O., 1981:6).

This accommodation is strictly that, and whatever supervision there is, is provided by untrained persons. Rates of subsidy vary from city to city; MCSS sets a maximum rate each year for which cost-sharing is available. The prospective resident must be eligible for General Welfare Assistance to qualify for a domiciliary hostel. The cost of the Domiciliary Hostel Program is shared 50/50 by MCSS and the federal government. MCSS maintains a record of hostels supplied by the various municipalities. According to this record, 13 per cent of hostel beds in 1981 were occupied by ex-psychiatric patients.

As noted in the discussion of alcohol and drug treatment services, MCSS funds the Halfway House Program under the Charitable Institutions Act targetted to persons with alcohol and drug addiction problems. There are 26 houses in the program, some of which have programs operated by Alcoholics Anonymous.

4.2.3 Ministry of Municipal Affairs & Housing

The Ministry of Municipal Affairs and Housing (MMAH) is responsible for the supply of affordable, decent and self-contained housing across the province. In order to stimulate this supply, MMAH provides capital funding and subsidy programs for municipalities, charitable/non-profit organizations, co-operatives and individual entrepreneurs and corporations. This is usually done in some form of partnership or co-operation with Canada Mortgage and Housing Corporation (CMHC) which has access to federal funds.

MMAH, through the Ontario Housing Corporation (OHC), provides rent-geared-to-income housing in more than 300 communities across the province. Much of this housing is managed by local housing authorities (LHA) on behalf of the OHC. This housing program serves qualified applicants, including families, senior citizens and both physically handicapped and mentally retarded persons who are able to live independently. No support services are provided. One of the problems is that the eligibility criteria exclude single persons under the age of 60. Even if they were eligible, there is no suitable accommodation for singles in many places because most rent-geared-to-income housing is designed for couples and families. Thus, the access of psychiatrically disabled individuals to OHC rent-geared-to income housing has been limited.

The rent supplement program is also administered by the OHC through the local housing authorities. MMAH negotiates the agreement with the landlords to make vacant units available to qualified applicants on a rent-geared-to-income basis. Under special rent supplement agreements, disabled persons requiring attendant care and residing in special independent living accommodation benefit from the rent-geared-to-income scale. The Ministry of Community and Social Services provides home support services including various types of personal care, housekeeping, meal preparation and laundry service. Food costs are borne by the residents. There are, however, few vacant units in the major urban centres.

In March 1981, the MMAH initiated the Ontario Community Housing Assistance Program (OCHAP). This program is intended to supplement private non-profit and co-operative housing programs administered by the federal government to provide units to persons eligible for geared-to-income accommodation. Under OCHAP, Ontario pays 100 per cent of the difference between the geared-to-income rent and the monthly rent required for the accommodation.(1)

The MMAH also provides staff and financial assistance to municipally-owned non-profit corporations whose purpose is to provide adequate low-rental accommodation for families and individuals.

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(1) Canada Mortgage and Housing Corporation has funds available under the Non-Profit Housing Program for charitable organizations wishing to provide housing for "special care" clients.

4.2.4 Municipal Governments

Municipal governments influence the supply of housing in general, and specific types of housing and living arrangements, through their use of zoning, health, welfare, safety and similar bylaws. This is particularly true with respect to group homes.

4.2.4.1 Group Homes and Restrictive Zoning

The term "group home" has a specific legal meaning under the Municipal Act, s. 236(1)(a). The Act defines a group home as a single housekeeping unit in a residential dwelling in which three to ten persons, excluding supervisory staff or receiving family, live as a family under responsible supervision consistent with the particular needs of its residents. The home is licensed or approved under specific provincial statute by one of three Ontario Ministries (Health, Community and Social Services and Correctional Services) and in compliance with municipal by-laws.(1)

Each piece of legislation sets out the standards that must be met before a residence can be established under that legislation to ensure that homes are properly operated. Provincial administrative and procedural requirements are defined for the accommodation program under which the group home is established in addition to the standards and requirements developed by the sponsor of the facility.

Some municipalities, through restrictive or exclusionary zoning, have prevented group homes from being established. The usual procedure is for the municipality to establish a policy in its official plan, and/or a municipal zoning bylaw, which states that in designated residential areas of the municipality only "family" housing will be allowed; the term "family" is defined as meaning persons related by blood or marriage. This approach is used, for example, to prevent residents from renting out a room or basement apartment as well as the establishment of group homes.

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(1) One of the difficulties in dealing with the question of group homes has been that, as they are defined in the Municipal Act, they are confused with a variety of other residential living arrangements or other types of community services or facilities which have a residential component; for example, boarding homes, hostels, crisis intervention centres and rest homes.

Exclusionary zoning has been a major issue in municipal politics, and in municipal/provincial relations, over the past 15 years, particularly as MoH, MCSS and Correctional Services began to deinstitutionalize and place increasing emphasis upon the establishment of alternative community living arrangements. At the heart of the problem is the perceived effect the establishment of group homes in a neighbourhood has upon quality of life in the neighbourhood and upon house values.

Several attempts to resolve this situation have not proved wholly satisfactory. In 1973 the Ontario Advisory Task Force on Housing Policy (Final Report, August 1973:19) recommended that municipal planning should be directed to the housing unit and not to the type of occupant. In 1977 the Ontario Planning Act Review Committee tackled the issue on the basis of two principles. The first was that it was not the proper exercise of municipal planning authority for the residents of an area directly, or through their elected representatives, to determine who is not to live in that area on the basis of age, marital or family status, source of income, life style or any other personal characteristic. The second principle was that municipalities should not be entitled to carry out residential planning policies in ways which impair the achievement of provincial or, where applicable, regional housing policies - for example, provincial policies regarding community living arrangements for special needs groups such as ex-psychiatric patients (Ontario Ministry of Housing, 1977:130-131).

Because of the various court decisions regarding the definition of "family" and municipal rights, and for other reasons, MMAH deleted clauses to this effect from the revised Planning Act (1983) as unnecessary. Where municipalities adopt exclusionary zoning bylaws, the procedure is for individuals or agencies who operate or sponsor group homes to apply to the municipal government for an amendment to the bylaw. If this application is not successful, an appeal can be made to the Ontario Municipal Board. This can be a somewhat time-consuming and expensive process, and may limit the ability of MoH, MCSS and other ministries to implement provincial policies. MMAH also encourages municipalities to make provision for group homes in their official plans as part of their responsibilities to their residents; and it has been working with individual municipalities to encourage them to adopt a broader, as-of-right provision for group homes in their zoning bylaws.

One of the long-standing beliefs of many homeowners is that the presence of group homes lowers neighbourhood real estate values. However, a study of real estate in Ottawa concluded that property values were not adversely affected by the presence of group homes (Goodale and Wickware, 1979). A more recent study of five Metropolitan Toronto neighbourhoods found that neither sale prices nor turnover rates by volume of sales were significantly affected by the introduction of group homes (Dear and Taylor, 1982) and there is evidence from Alberta (Berger, 1981) that neighbours can want to help and work with residents of group homes. Nonetheless, opposition continues (A.M.O., 1982:1 and 2).

Another problem is that the major 'institutional' ministries - Health, MCSS and Correctional Services - all implemented substantial deinstitutionalization and non-institutionalization policies at about the same time. Consequently, many local municipalities found themselves facing an unprecedented demand for group homes, were not prepared for them and were concerned about the social and other services needed to serve the group home populations. In some municipalities there was also a certain amount of resentment created because residents felt that they were being asked to agree to group homes for people who came from other municipalities.

In many municipalities across the province a hierarchy of 'least desirable' group homes has developed. Homes for physically handicapped children and senior citizens rank among the least undesirable or the most acceptable. At the bottom of the hierarchy as 'most undesirable' are group homes for offenders funded by Correctional Services, the John Howard Society and others. Unfortunately, many people seem to consider citizens who are ex-PPH patients as closer to the bottom of the hierarchy and among the more undesirable residents. Such attitudes are long standing, rooted in medieval, and not so medieval, attitudes towards 'insanity'. There was an instance in

Etobicoke, for example, when some residents opposed the introduction of a group home for the mentally retarded on the grounds that neighbourhood children could be 'infected': one public meeting ended in physical violence. Some communities' early experiences of group homes also gave credence to the belief that the residents of such homes were often not well supervised or involved in regular programs. The resulting fear was that idle residents would likely create problems for the community, e.g., loitering.

As more and more Ontario residents make use of mental health services this attitude will, one hopes, wither away; but withering can be a long time coming and in the meantime many Ontario residents are suffering from inappropriate accommodation because they happened to have spent some time in a psychiatric institution or to have been under the care of a psychiatrist.

The irony is that some number of persons opposing the presence of ex-PPH persons in their midst have, themselves, likely received psychiatric help -but from a private psychiatrist or perhaps in a GHPU, general hospital or private hospital.

For the past year, the Secretariat for Social Development has been carrying out a program to improve the public's perception of group homes generally. In addition, in April 1983 the MoH gave a grant of $1.5 million to the Ontario Division of the Canadian Mental Health Association to develop a major educational program and awareness campaign about mental health and the needs of the mentally ill. One can only hope that these two programs will go some distance to improving the public's appreciation of and attitude towards mental illness.

The battle is being won slowly. Currently, there are more than 1,000 group homes across the province serving a variety of special needs groups. Municipalities representing about 74 per cent of the population of Ontario have already approved or are considering a group home policy including, for example, Hamilton, Ottawa, Kingston, Barrie, Windsor, Mississauga, London and smaller centres such as Vanier and Nickel Centre. Metropolitan Toronto has proposed a policy to permit group homes in all residential areas, with the exception of Correctional Services group homes which would be permitted only on arterial roads. If approved by the OMB, this policy would require all area municipalities in Metro to permit group homes. The matter has been referred to the OMB and will likely be heard by early 1984.

4.2.4.2 Boarding Homes and Lodging Houses

The majority of ex-provincial psychiatric hospital patients in most Ontario communities reside in commercial rooming or boarding homes without support services (A.M.O., 1981:11; Houselink Community Homes, 1980:6). In Metro Toronto, which has the highest concentration of ex-psychiatric patients, it was estimated in the summer of 1981 that private boarding homes accounted for approximately 30 per cent of the total number of beds available to psychiatric patients in Metro Toronto (Supportive Housing Coalition, September 30, 1981:4).

The majority of these residents are unemployed and receive either General Welfare Assistance or Family Benefits Allowances, which is often insufficient to purchase appropriate accommodation. They, therefore, tend to gravitate towards commercially-operated boarding homes where the rent is more within their means. With the increasing conversion of older homes to other residential uses, the availability of even this type of accommodation has seriously declined (A.M.O., 1981:6).

The regulation of boarding homes and lodging houses falls within the authority of municipalities. These homes are privately owned, profit-making and generally offer few or no support services to residents. These homes can house up to 65 persons.

The residents of these homes should have the assurance that their living conditions meet basic standards related to health, fire and safety. Under Section 208 (60) of the Municipal Act, municipal councils are authorized to pass by-laws providing for the licensing, regulation and inspection of boarding or lodging homes. Municipal regulation can take the form of registration, licensing, or a combination thereof, as deemed appropriate by the municipality. In this manner, municipalities are able to satisfy themselves and the residents of these homes that standards are in force for everyone's protection.

A number of municipalities are taking steps or considering action to regulate these homes. A recent example is Hamilton which has established regulations for two levels of boarding and lodging homes. The Municipality of Metropolitan Toronto Report on Adult Residential Facilities (1979) recommended that its area municipalities take action in accordance with powers granted to them to license, regulate and inspect all these residences. Many municipalities, however, have yet to accept their legitimate responsibilities in this area (A.M.O., 1982:1 and 2).

Programming is not typically provided as a component of this type of accommodation. Community Occupational Therapy Associates does, however, provide training and education services to some boarding home operators in Toronto, as well as support services in, for example, the management of difficult residents. COTA also works with the home residents in establishing residents' councils or self-help groups. Currently (September 1983), COTA is servicing 10 homes with this program; each home receives one or two visits a week from COTA staff.

4.2.4.3 Private Sector

Among the non-profit private sector organizations, the Salvation Army is undoubtedly the major provider of accommodation. The accommodation in their Men's Social Services Centres, which are essentially hostels, offer no programs and residents must be out of the building between 8 a.m. and late afternoon. There are nine such Centres across the province with a total of 1,019 beds, 434 of which are in the Centre in downtown Toronto. This accommodation is directed primarily towards the indigent, some unknown proportion of which are former psychiatric patients.

The Salvation Army also provides homes for specified target groups of women: unmarried mothers, retarded and alcohol and drug abusers. Here again, some unknown proportion of these residents are former psychiatric patients. The Army has several homes across the province for senior citizens. It is likely that some residents in these homes have been psychiatric patients.

Other church organizations also provide accommodation of various kinds, but on a more limited scale. In addition, labour unions and others are establishing co-operative housing projects. To the best of my knowledge, none of these are specifically targetting the psychiatrically disabled.

The other important private sector, of course, is the for-profit sector which has been discussed with reference to boarding homes and lodging houses.

4.3 OTHER REHABILITATION AND MAINTENANCE SERVICES

Other rehabilitation and maintenance programs fall into three general categories:

- Vocational and education rehabilitation;
- Social and recreational services;
- Life skills training.

Vocational and educational services include such components as vocational assessment, training and re-training, transitional employment opportunities and sheltered workshops, and job search training.

All ten provincial psychiatric hospitals offer some form of vocational "activities" to some of their inpatients. There is great variability from PPH to PPH. Some, for example, offer vocational rehabilitation programs for both inpatients and outpatients. These programs are designed to assess, teach and enhance work-related skills. In most cases, these PPHs include as part of their programs an industrial workshop which offers an "incentive wage" to participants. Some of these vocational rehabilitation programs are substantial. For example, the Lakehead Psychiatric Hospital in 1981/82 provided approximately 10,600 inpatient and day-care days in its industrial workshop and hospital services program for vocational rehabilitation. The Queen Street Mental Health Centre has not only one hospital-based workshop for inpatients but also three community-based workshops for outpatients as well as hospital services (in-hospital work programs: e.g., laundry, kitchen). The London Psychiatric Hospital and Kingston Psychiatric Hospital each have one hospital-based industrial workshop and one satellite industrial workshop in the community. Some of the vocational rehabilitation programs are, however, more limited.

Vocational Rehabilitation Services (VRS) funded by MCSS is a program directed towards individuals 16 years of age and older who have physical or mental disabilities which have resulted in a vocational handicap. Services provided by VRS are designed to prepare clients for employment. People are not usually accepted into these programs unless they are considered to be vocationally "rehabilitable"; consequently, these programs are not usually available to those persons requiring maintenance rather than rehabilitation services. It is estimated that about 25 per cent of the people served by VRS are psychiatrically disabled (MCSS, 1983).

In addition, MCSS funds approximately 164 workshops, most of which are operated by local organizations for developmentally handicapped persons; about 11 per cent of the population served by these workshops could be considered to be psychiatrically disabled (MCSS, 1983).

Psychiatrically disabled persons also use general vocational services provided by a variety of community agencies; for example, the Salvation Army, Jewish Vocational Services and the YM/YWCA.

Two community colleges - George Brown and Seneca - offer a Rehabilitation Through Education program designed for persons who have experienced psychiatric problems. In addition, many community colleges offer a number of employment training programs which are available to the psychiatric client: Basic Training for Skills Development, Industrial Orientation, Basic Employment Training and Job Readiness.

Social and recreational components are provided by many of the rehabilitation services funded by the Ministry of Health's CMHS Program. The purpose of these components - some of which are programs unto themselves - is to develop communication, social and leisure skills.

There are a number of other community and volunteer organizations which provide social and recreation programs or opportunities for this specific population but it is difficult to obtain information without systematic canvassing across the province. Also, a number of municipalities employ special needs co-ordinators for recreation services for mentally and physically disabled persons. I have had suggestions that many of these co-ordinators are not well versed in the philosophy of normalization and tend to stream the disabled into separate programs which do not call upon their full potential.

The Recreation Division, Ministry of Tourism and Recreation, has a consultant responsible for encouraging recreation services for persons with a physical or mental disability. The roles of the consultant are to consult with and provide grants to municipal recreation departments, provincial organizations, community groups and others; and also to provide resources and training to instructors and staff in recreation services for disabled persons.

Many of the rehabilitation programs funded by CMHS include life skills training. Life skills training programs are designed to teach those skills required for personal competence at home, at work and in the community. The skills include budgetting, buying and preparing food, using public transportation and other homemaking and daily living activities. There are no hard and fast distinctions among life skills training, social and recreational and some vocational and general rehabilitation programs because they tend to cover some of the same ground. For example, life skills training is an integral component of the employment training programs offered by the community colleges.

Typically, as the discussion above implies, the different components of rehabilitation and maintenance services are provided by different agencies in different locations. However, there are a small number of exceptions. The Causeway program in Ottawa, for example, offers a comprehensive range of these services in one location. The Western Ontario Therapeutic Community Hostel in London provides both a place to live and a variety of on-site rehabilitation and maintenance programs.

5.0 PREVENTION

Essentially, there are three types of mental health prevention programs: primary, secondary and tertiary. They can be defined as follows:

- Primary prevention: directed at reducing the incidence of new cases in a population by the introduction of programs aimed at the population at large or target groups within the population.
- Secondary prevention: directed towards reducing the number of existing cases of a disorder or dysfunction through such techniques as early identification and active treatment.
- Tertiary prevention (or rehabilitation): directed towards reducing the after-effects or deficits of disorders or dysfunctions.

The concept of three levels of prevention follows from the successful "medical" models which have been used for dealing with physical conditions. The translation of the medical model into the mental health field has not, however, been easy or straightforward.

The lines of demarcation between primary, secondary and tertiary prevention are blurred, an inevitable result of the wide-ranging effects which various types of prevention programs can have. A prevention program directed to primary, secondary or tertiary target populations can have spillover benefits for other target populations.

5.1 PRIMARY PREVENTION

Of the three levels of prevention in the mental health field, primary prevention has been the most neglected. In 1975, an expert in the field noted that primary prevention was probably the least understood and the most neglected of all public health concepts in the field of mental health (Goldston, 1975, as cited in Ontario Ministry of Community and Social Services, 1979:1). Just a few years later, however, another expert described primary prevention as "Zeitgeisty", very much the current fashion (Cowen, 1982:133).

Primary prevention in the mental health field is also the most difficult of the three levels to define and describe. In her discussion of the subject (Ontario MCSS, 1979), Dr. Naomi Rae Grant noted some of the terms used to describe primary prevention: "benevolent gambling", "more cost than benefit", "Our Holy Grail", "corralling a cloud". Another researcher confessed that in his more cynical moments he believed that primary prevention was whatever was labelled as such (Cowen, 1982).

Primary prevention is directed towards reducing the incidence of new cases in a population. It refers to activities, of both proven and presumed efficacy, to prevent specified disorders or dysfunctions. These programs typically adopt one of two basic strategies: modifying stresses in the environment which lead to the disorder or dysfunction; or improving the ability of the individual to cope with the stress, for example, by improving competence (Ontario MCSS, 1979:1).

Primary prevention programs are characterized by their focus on a group or general population rather than upon an individual and by their implementation on a before-the-fact basis; that is, targetted to populations not yet experiencing mental health maladjustment - although they may be in the high risk category such as the recently bereaved or the children of disturbed parents. Primary prevention programs should also be intentional, in the sense that they are founded on a knowledge base from which one can infer that a given program has the potential for achieving specified results or objectives. The implication is that there should be a research base from which one can derive specific objectives (Cowen, 1982:132).

There are not, however, a multitude of proven models of effective primary prevention programs. Also, while there are ample statistics to demonstrate the need for effective primary prevention programs, there is not a substantial body of research upon which to draw to develop such models. Primary prevention in mental health is difficult to grapple with, it is diffuse and many variables are at work, starting with the genetic structure of the individual and ranging through all the environments in which the individual lives, works and plays.

The most systematic, long-term primary prevention effort in Ontario is the public health unit. With respect specifically to mental health, the public health nurse is an important front-line resource. In the discussion of them in Gatekeepers and Pathways, their specific activities with respect to mental health were detailed.

A reasonable objective is to establish primary prevention programs which have a demonstrated ability to influence target populations in a cost- effective manner with results which can be measured in some manner adequate for evaluation. Two such generic types of programs have considerable potential in this regard. The first type is in the field of recreation and physical fitness. The second type of program is based in the work place and involves employee counselling programs. Both types of programs are well developed and there is a considerable body of information concerning their effectiveness.

These programs have several advantages. They have specific objectives. The target populations are well defined. Results are measurable and costs can usually be established against program effectiveness.

These generic programs are examined in detail in a Background Paper to this study entitled 'An Overview of Employee Health Promotion Programs and Preventive Mental Health in the Workplace' (Pearl and Berger, 1983). In the following paragraphs the nature and results of these programs are summarized and their implications for primary prevention in mental health are discussed. The programs overlap to a considerable extent, but they are discussed separately.

5.1.1 Physical Fitness Programs

The beneficial effects of physical fitness programs upon physical well being and illness have been well documented. The use of such programs in the work place is rapidly spreading across North America. More recently, attention has turned to the effects of physical fitness programs upon the mental health of participating employees. For example, one longitudinal study of the effects of employee recreation programs upon Canadian and U.S. employees found not only improved levels of physical fitness (e.g., increased oxygen flow to the brain, stronger heart muscles), but also higher aggravation tolerance levels, increased productivity, greater assertiveness and reduced absenteeism and job turnover: all factors related to an employee's mental state (Carter and Wanzel, 1975).

A review of this type of program in Russia obtained similar results: not only improved physical fitness and reductions in sick days absent, but also improved mental labour productivity, working capacity and creative activity (Pravosudov, 1976).

One of the best studies of its kind concerns the Canada Life Assurance/North American Life Assurance study to assess the effects of a worksite fitness program on productivity-related and health costs (Peepre, 1980). Canada Life employees were involved with a fitness and recreation program and acted as the experimental group; North American Life employees were the control group. The results as they pertain specifically to indicators of mental health are significant.(1)

The results showed that among "high adherence" program participants absenteeism was reduced by 42 per cent over the study period which, if calculated at $50 per diem for the entire Canada Life work force, would constitute a savings to the company of some $175,000. Similarly, job turnover among participants was reduced from about 15 per cent to 1.5 per cent, constituting a savings to the company, assuming all workers were involved, of some $510,000. Visits to the staff doctor among female program participants were less than half those of non-participating female employees. On self-reporting measures, about half the program participants reported they were more alert, had better rapport with co-workers and supervisors, and generally enjoyed their work more since joining the program.

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(1) The results as they pertain to improved physical health indicators such as reduced demands on medical services and sick days absent are equally impressive, but these lie outside the domain of this discussion.

Ontario Hydro's four-month pilot project for their Employee Fitness Motivation Program obtained similar results. Physical fitness measures improved considerably, including substantial reductions in the risk of heart attack. Between 75 per cent and 94 per cent of the participants reported improvements in the following areas, all related to mental health indicators: increased self-confidence, improved self-image, less stress and tension and a more relaxed feeling, greater ability to cope with stressful situations, more positive attitude and greater enthusiasm toward work, increased levels of job satisfaction, perceived improved work performance, and improved sleep and rest.(1)

Although these results are based upon the self-reports of respondents, they are consistent with the scientific evidence regarding the effects of physical exercise on stress responses, stress coping strategies and overall well-being. The evidence does not suggest that physical fitness programs result in any changes to basic personality structure.

Xerox, which provides a comprehensive employee lifestyle and health promotion program, has not attempted to evaluate the costs and benefits of the total program. But, it did examine the value of the physical fitness component as perceived by employees, program managers and senior management. Objective indicators identified significant improvements with respect to self-concept and trait anxiety among those who exercised regularly. More important however, in the opinion of the Director of Health Services at Xerox, was "the multiple informal indicators that program participants and non-participants, at all levels in the company, honestly believe that this program is cost-effective in its contribution to employee job satisfaction, company loyalty and productivity. In short, the Physical Fitness Programs are considered to be effective in cost containment because so many individuals believe they are." (Wright, December 1982).

The potential for these programs is not restricted to large organizations. The Recreation Division, Ministry of Tourism and Recreation, has been actively involved in promoting work place and public physical fitness programs for some years now. They inform us that they have been receiving an increasing number of requests from smaller companies - 10 employees or less - for assistance in establishing work place programs.

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(1) Dr. Thomas Hamilton, Manager of Health Services, Ontario Hydro, personal interviews, Spring 1983.

There is no reason to assume that the mental health benefits of physical fitness programs are different in the work place than they are in the general community. Unfortunately, not a great deal of research on this subject has been carried out in the community setting (Berger et al, 1983a:2). There is, however, anecdotal evidence regarding the importance of recreation programs in high risk communities. Recently, an economic impact analysis of recreation activities (Berger et al, 1983b) disclosed an increasing rate of public involvement in and demand for recreation programs in Sault Ste Marie, a community suffering a 25 per cent to 30 per cent unemployment rate. The evidence suggests that unemployed workers are holding on to their recreation dollars as long as possible, maintaining family memberships in "Y" and other programs, for example, even after giving up on other areas of discretionary spending.

Sault Ste. Marie municipal recreation officials stated that recreation programs have played an important role in protecting the social fabric of the community, and in maintaining the mental well being of many of its residents, during this period of acute and continuing economic stress. If the public did not believe that recreation was satisfying and beneficial, they would not be spending scarce dollars on it, and municipal officials would not be expending scarce resources to maintain existing programs and to develop new ones.

In short, there are a number of models in place of demonstrable effectiveness with respect to physical fitness programs and mental health in the work place (and, potentially, in the community setting). The continuing growth of these work place programs in the corporate and government sectors indicates the existence of ready-made, long-term vehicles for the expansion of primary prevention programs in mental health.

5.1.2 Employee Assistance Programs

The same is true for Employee Assistance Programs (EAP). EAPs have their roots in alcoholism and rehabilitation counselling, and have expanded their mandate over the past decade or so into the broader area of mental health. The term 'employee assistance' is not well defined and covers a range of programs from mandatory referral for alcohol counselling to voluntary counselling for troubled employees to mental health education programs.

The number of Ontario firms using some form of EAP is not known, although it appears to be substantial. A 1975 study by ARF identified 348 such firms in Ontario, although ARF concluded that this was certainly an underestimate of the total number. A 1983 ARF study indicated 97 out of 500 major Metro Toronto companies had an EAP of some description.(1)

Several programs are worth noting. Ontario Hydro is a pioneer in the field with the appointment of a clinical psychologist on staff in 1954. It established a written policy in 1952 on alcohol abuse as a medical problem requiring treatment, but the program for psychological problems has operated informally for 30 years and a proposal is in place for formal recognition of the EAP.

Between 1952 and 1968, the Hydro program had a rehabilitation rate of only 15 per cent, judged by the usual criteria that the participant was still alive, still employed or in normal retirement, still with a family, still in a stable community situation and still off alcohol or drugs. A major reason for the low penetration rate was the lack of treatment facilities. In 1969, the Addiction Research Foundation established the first such treatment facility in Ontario. By 1976, Hydro's rehabilitation rate had climbed to 60 per cent because of the availability of the May Street Clinic (Hamilton, 1982:3).

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(1) **Wayne Ogg, Consultant, Employee Assistance Program Centre, Metropolitan Toronto, Addiction Research Foundation, personal interviews, Spring 1983.**

About 90 per cent of the Hydro participants are voluntary. Although the rate of participation has not changed - about 1/1,000 employees -the participants are coming forward earlier, increasing the chances of rehabilitation.

Hydro's Manager of Health Services has estimated the costs to the corporation of sickness absence due to emotional illness and emotional/social considerations in 1981 to have been in excess of $5.6 million, and the costs of seven suicides in that year - including pension, insurance, benefits to survivors, new recruitment, replacement training - at $200,000 each or $1.4 million in total. In comparison, he estimated the costs of the EAP at $51,750 for the psychologist's time devoted to emotional/social problems and $55.96 for each employee seen (lost work time over an average of 3.4 visits), plus $64,800 for additional psychologists' time if the program is successful (Hamilton, 1982:17-20).

The Toronto Region of Imperial Oil began an EAP in mid-1980 and achieved a penetration rate of nine per cent in the first year. This is consistent with estimates that five to ten per cent of any population have pressing problems which need immediate attention. The most frequent areas of concern are family, marital, stress, phobias and anxiety. The EAP Director estimates that the program saved the company 1,500 man days of absenteeism among program participants in the first year of operation.(1)

The Ontario Government offers an extensive EAP which is available to all 80,000 provincial government employees. The program is operated by the Ministry of Government Services, Human Resources Services Division, Employee Advisory Services Branch (EAS). EAS began in the 1960s as an alcohol program and by the late 1970s had expanded definitely into the broader area of employee assistance.

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(1) Dr. Sam Klarreich, EAP Director, Imperial Oil, Toronto Region, personal interviews, Spring 1983.

The program is the largest in Canada in terms of the work force it serves. It also appears to be one of the most comprehensive, including even advisory services on day care for children. The program has an active caseload of about 400 persons at any one time and the staff include 18 counsellors. A consulting psychiatrist is available to assist counsellors. Referrals to community agencies and resources are made as appropriate. The program budget is $573,000 (1983/84) and an evaluation study is underway. Although the evaluation results are not yet available, EAS client followups on a three-month basis indicate that 75 per cent to 80 per cent of the clients expressed satisfaction with the program and found the counselling to be effective (1)

The EAS consists of three components:

- General counselling - available to any public servant who wishes to use it or who is referred by his or her manager or supervisor.

- Rehabilitation - available to employees who have been absent for 15 days from work. The employee's ministry brings the file to the attention of EAS who contacts the employee regarding the need for rehabilitation counselling. If the employee wishes counselling, it is provided. All but three ministries are using this program: as EAS adds staff, the other three ministries will be included.

- Management of Work Performance - a training and guidance program for managers and supervisors on how to recognize employee problems, how to manage troubled employees and related matters.

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(1) Byron Pulsifer, Manager, Employee Advisory Services, Ministry of Government Services, personal interview, September 26, 1983.

The EAS is in a separate building from the Human Resources Services Division. All its files are confidential. Specified parts of the file can be released to designated individuals only with the written consent of the client. Designated individuals might include family members, work colleagues and managers, which allows for a comprehensive approach to the employee's situation. About 40 per cent of the problems presented by clients are job related; the remainder involve marital and family, addictions, legal and debt problems.

The Addiction Research Foundation has the potential to become another major provider of EAPs, with primary emphasis upon alcohol and drug abusers. In 1980 the ARF signed a formal working agreement with the Ontario Federation of Labour to train occupational health consultants and trade unionists in the development and implementation of "Employee Recovery Programs" for all unionized worksites in Ontario. The ARF reports that it is emphasizing work place programs because research evidence indicates that "less deteriorated populations" - i.e. persons still employed - are much more likely to respond favourably to treatment.

The Canadian Mental Health Association has become involved in EAPs through its Project HELP program. This began in 1975 as a fee-for-service to corporate and other organizations. Project HELP provides EAP program design and administration, education and training for managers and supervisors, and counselling services to employees. Referrals are provided as necessary. A similar service is provided by the Family Service Association of Metro Toronto.

The types of programs described above are examples of primary prevention programs which have proven effectiveness. There are established networks and resources upon which to build objective-specific programs in a planned manner with evaluation incorporated in order to identify benefits. Perhaps the most attractive feature of these programs is that they are already in existence, are strongly supported and funded by the private sector and have considerable growth impetus upon which the MoH can build.

5.1.3 Employee Health Promotion and Lifestyle Programs

These are programs which incorporate physical fitness and recreation, EAPs and also lifestyle and behaviour modification programs in a comprehensive approach. For example, the LIVE FOR LIFE program implemented by Johnson & Johnson in the United States deals with such matters as smoking, nutrition, weight control, stress management, fitness and health knowledge. LIVE FOR LIFE is available to all 22 companies of Johnson and Johnson. Once a company decides to participate, Johnson & Johnson provides consulting expertise, training, core program components, professional services and promotional materials. There is no charge to the participating employee, participation is voluntary and, with some exceptions, off company time. The program is currently being evaluated. Anticipated results include positive changes in employee morale, job satisfaction and productivity, reductions in absenteeism, accidents and total illness care costs.

Control Data's STAYWELL Program is similar to LIVE FOR LIFE. Employee participation ranges from 65 per cent to 95 per cent, depending upon the work site. Surveys have shown that participation is highest at worksites where people do less travelling, among women and among those with higher education (Naditch, 1983).

5.2 SECONDARY AND TERTIARY PREVENTION

Mental health secondary and tertiary prevention programs are, perhaps, the easiest to deal with; they are certainly the easiest to describe. Secondary prevention is directed towards reducing the number of existing cases of a disorder or dysfunction through such techniques as early identification and active treatment. Tertiary prevention is directed towards reducing the after-effects or deficits of disorders or dysfunctions; in this sense it is closely related to rehabilitation and maintenance, particularly in terms of preventing a deterioration of the existing condition or recurrence of the former psychiatric condition.

An example of a secondary prevention program related to mental health is the Early Identification Program which the local school boards are required to carry out for all elementary school students. The program follows the well-established stages of screening, identification and treatment and, in that respect, is similar, for example, to the anti-tuberculosis program. There are a number of such programs. While not all of them are directed specifically towards conditions pertaining to mental health/illness, some of them do have the result of identifying deficits in this category; for example, post-natal screening of infants for the identification of developmental delay.

The difficulty which secondary prevention programs in mental health face is that the symptoms of mental illness are not always well defined or readily identified, nor is there a clear understanding or agreement on the causal factors. Mental illness involving mixed causes, such as schizophrenia, are possibly the most easily identified, but even in the case of schizophrenia the symptoms may not manifest themselves until the illness is well rooted and there are problems associated with accurate diagnosis and treatment. In the case of mental illnesses with organic components, treatment often is limited to intervention directed towards controlling the symptoms so that the individual can be maintained at a reasonable level of functioning rather than towards effecting "cures".

For those mental illnesses which are not organically or genetically based, screening procedures are improbable and impractical. Practically speaking, for the most part we must rely upon individuals "screening" themselves and seeking assistance. The concern, therefore, in the area of secondary prevention is developing networks of information and referral which will improve the chances that the individual will seek at an early stage the type of assistance most appropriate to his or her condition. In such networks, the roles of the gatekeepers, particularly the general practitioner, are key.

For all practical purposes, tertiary prevention is provided by the rehabilitation and maintenance programs described earlier. These programs are directed towards reducing the after-effects of the mental condition, improving the competency of the individual and assisting him or her to return to normal life or to live in an environment as close to normal as is possible, given the condition.

The MoHs Community Mental Health Services Program funds only six programs which are categorized under "Prevention" and they are not differentiated by level of prevention. These include a program for spouses and parents in Windsor suffering from the effects of bereavement; another serves women in the Niagara Region who have suffered mental or physical abuse; a third is directed towards female ex-psychiatric patients and socially isolated women in North York; and the fourth provides information, resources and community organization services to individuals and organizations in the Hamilton area.

To these programs, however, should be added the many programs and activities - many, but not all, supported by government - involving self-help groups, church groups, addiction counselling, family counselling and other activities which are directed towards assisting people in dealing with conditions which affect their mental state. The self-help groups are particularly interesting because they are so well focussed on their target population - ex-psychiatric patients and their families: examples include, On Our Own, Recovery, Inc., Friends and Advocates.

It is not always easy, or necessary, to differentiate between secondary and tertiary prevention programs, particularly when we are dealing with non-organic mental conditions. The prevention programs noted in the previous paragraphs could, in some cases, be described as either secondary or tertiary; and some do a bit of both. The more important question is the extent to which the various prevention service providers, including all gatekeepers, have defined their roles, are aware of the roles of other providers and have established sufficiently strong referral and co-ordination mechanisms to facilitate the provision of the most appropriate prevention program to the individual in need.

6.0 VOLUNTEERS

The contribution made by volunteers and volunteer groups to mental health care service delivery, particularly to high risk mental health clients, is almost incalculable. As the Ontario Council of Health concluded in Agenda for Action (1979): "Without the participation of volunteers, singly and in groups, the mental health services system would falter, if not fail completely in meeting its goal. The individual volunteer who befriends a patient, serves on a telephone 'hot line', helps at a drop-in centre, supports the work to be done in mental health by personal effort or financial donation is essential." It has been suggested (Fahey, 1983:6) that for every person who is disabled and in a formal system of care, there are two others who are cared for by family, friends or neighbours.

In this discussion a distinction is made between volunteers who as family, friends and neighbours help an individual they know, and those who belong to an organization which assists any individual who falls within its mandate. The value of family, friends and neighbours to the mental health care system is enormous and almost impossible to calculate. However, if this "informal" support system is to function effectively - especially with respect to rehabilitation and maintenance - then one should look to a strong family support service network to help these people.

The focus of the remainder of this discussion is the organized volunteer sector. Volunteer organizations, and various other groups such as churches, often provide the context of such care.

The role of the volunteer in management and administration is also prominent. Volunteers, both lay and professional, are involved as members of management and advisory boards of general hospitals, psychiatric hospitals, mental health associations, community agencies, and as members of social planning councils, district health councils and the host of organizations and services which constitute the backbone of mental health services across the province. It may be possible for hospitals to function effectively without volunteers, but almost all local mental health organizations and services would founder without volunteer assistance; most exist because of the dedication of volunteers in fund raising, management and assistance in the provision of services.

It is useful and sobering to provide some estimate of the public's indebtedness to the volunteer and to volunteer organizations. In 1979 approximately 978,000 people in Ontario were involved with some form of volunteer organization (Table III-25). Of this total, about 81,000 were involved with a 'health care' organization and an additional 320,000 were involved with a 'social/welfare' organization (Statistics Canada, 1981). 'Health care' organizations include health delivery service agencies providing physical and mental health services directly to the public. 'Social/welfare' organizations include those involved in fund raising, social information/advisory services, child care, services for the aged, service clubs and correctional services.

In its 1979 national survey of volunteers, Statistics Canada (1981) found that each volunteer spends an average of 126 hours a year on a given volunteer activity. As noted above, approximately 81,000 Ontario residents worked on a volunteer basis for a health care agency in 1979. The calculation is not straightforward because of double counting; however, it is estimated that 'health care volunteers' provided 8,416,078 hours of agency work in 1979 (Table III-25). Assuming their time was worth the average provincial wage of $10 per hour, and it was probably worth more than that, this means that in 1979 the value of health care volunteers was worth in excess of $84 million. A similar calculation for the 'social/welfare' volunteers indicates a total of some 33,248,701 hours and a value of almost $332.5 million. The total amount of volunteer time spent in both sectors exceeds 41.6 million hours and has a value in excess of $416 million.(1)

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(1) Statistics Canada (1981) also calculated volunteer time in terms of 'services' provided, regardless of the type of volunteer agency involved. These calculations indicated 100,000 volunteers provided some form of services directly to the public and 197,000 volunteers provided social/welfare services. These calculations, however, do not include health or social/welfare services involving management, administration, committee work or fundraising.

Table III-25

Volunteer Activities by Type of Agency: Ontario 1979

Type of Agency	# of Volunteers*	% of Volunteers*
Health Care	81,000	8.3%
Social/Welfare	320,000	32.7%
Education	169,000	17.3%
Leisure	192,000	19.6%
Religious	280,000	28.6%
Civic/Community	31,000	3.2%
Political	54,000	5.5%
Other	59,000	6.1%

* Total number of volunteers = 978,000; the column total is greater because of the number of volunteers working with more than one agency.

Source: Statistics Canada, 1981.

These figures represent a net addition to the provincial economy and do not include the value of out-of-pocket expenses by these volunteers or their financial contributions to the various agencies. One cannot determine how much of this time or financial contribution is allocated specifically to mental health services; but it is likely to be substantial given that many of the social/welfare organizations are heavily involved in services related to rehabilitation and maintenance services which are used by mental health clients.

The figures on volunteer organizations are somewhat misleading. They do not reflect the large number of volunteers associated with the various other types of mental health programs described in previous chapters. Conversely, those organizations listed as volunteer organizations are, in most cases, associated with some other treatment or rehabilitation program being offered by one of the hospitals or as part of a general community thrust by a local branch of the Canadian Mental Health Association.

The Canadian Mental Health Association/Ontario Division (CMHA/Ontario) is the largest of the volunteer groups. It is a non-profit organization operated by mental health professionals, ex-patients and lay people, which works through a network of 32 local branches across Ontario, all but three of which have at least one staff person. The Ontario Division employs a total of 150 staff persons in its branches, most of them involved in operating mental health programs, and has approximately 10,000 members, of whom approximately 3,000 are actively engaged in volunteer work (CMHA/Ontario Division, 1983).

There are two primary thrusts to the CMHA/Ontario Division mission: 1) to reduce dependency on the system of mass institution-based care and programs by fostering the development of community-based, individually- centered care and support systems; and 2) to instill action and informed commitment on the part of the general public toward mental health service changes and the concept of helping self and others (C.M.H.A./Ontario Division, 1982). It carries out this mandate through public education, advocacy and direct service, although the extent to which this broad mandate is carried out by the branches varies considerably across the province.

Some of the CMHA/Ontario Division's mental health programs at the local branch level are funded through the Ministry's Community Mental Health Services Program. These include numerous co-operative housing, prevention and rehabilitation programs. The Ontario Division also receives funding support from the CMHS for the activities of four Branch Consultants. The Association recently received a $1.5 million grant from the Ministry of Health to launch a public education campaign. Government funding, however, constitutes only an estimated 20 per cent of the total Ontario Division's core budget of the Association.(1) All branches obtain their core funding from United Way monies.

Other volunteer and charitable organizations and agencies provide a broad spectrum of direct services to the mentally ill including such organizations as the Salvation Army and Goodwill.

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(1) Excluding "special projects" funds from government sources; for example, the Ministry of Health grant for the public education campaign.

The number of self-help groups involved in the mental health field has increased greatly in the last several years. Patient self-help organizations include On Our Own: Ontario Patients' Self-Help Association, Recovery, Inc. (The Association of Nervous and Former Mental Patients), Friends and Advocates, etc. Self-Help in Toronto, a directory and resource handbook published by The Thistletown Foundation and Thistletown Regional Centre for Children and Adolescents, lists almost 100 self-help groups in Metropolitan Toronto alone, many of which although not directed specifically at providing support for ex-psychiatric patients, are involved in providing information, friendship and support to a wide spectrum of high risk persons. Examples include: Y.W.C.A.'s Teen Mothers Group, Parents Experiencing Perinatal Death Association, Bereaved Families of Ontario, Aid for New Mothers, Inc. and Rexdale Immigrant Women's Project.

The number of self-help and patient advocacy groups will probably continue to grow over the coming years. The number of persons requiring mental health services of some kind in Ontario has reached a size that sub-groups within that constituency are now, or soon will be, large enough to support their own particular interests and some of these will prefer to work outside the umbrella of the CMHA. Changing economic, social and family conditions encourage the growth of splinter interests: for example, the increasing divorce rate, and the subsequent effects upon the spouses and their children, have driven increasing numbers of them to seek some form or other of specialized "mental health" service such as single parent counselling.

The number of patient advocacy groups active in the field of mental health has also increased dramatically in the last ten years. This component of the volunteer sector includes, for example, Ontario Friends of Schizophrenics, The Association of Relatives and Friends of the Mentally Ill, Coalition on Psychiatric Services (an umbrella group representing eight provincial community organizations) and the Supportive Housing Coalition, an amalgam of Metropolitan Toronto service agencies and individuals interested in aftercare for people discharged from psychiatric facilities. They play an important role in bringing the mentally ill person's rights and service needs to the attention of the community-at-large, as well as raising funds for research in the area of their specific interests.

Although it is difficult to ascertain the full impact of the contribution of churches in the area of mental health, mental health workers across the province attest to the importance of that contribution. The churches provide an array of services such as pastoral counselling, homes for the aged, social/recreational programs for senior citizens and accommodation for, amongst others, mentally ill persons.

Volunteers can be found providing direct service in the community to persons in numerous other types of programs, for example, distress centres, neighbourhood/community centres, etc.

Social planning councils play a less direct mental health role but are an example of a body whose activities often serve persons with mental health problems as part of a broad social service mandate. The largest single activity to which the councils' energies are devoted is planning and research (Ontario Social Development Council, Committee of Social Planning Councils, 1980). They are also involved in other activities such as community organization and development, public education, service delivery (e.g., "Meals on Wheels" programs), advocacy, co-ordination of services, and fundraising. Almost half the funds for these activities come from the United Way, while another 20 per cent comes from municipal/regional government and a further 11 per cent from the provincial government.

7.0 PLANNING AND CO-ORDINATION

Planning and co-ordination services are designed to promote effective delivery of mental health services within a specific geographic area. Usually the activities include the identification of needs, development of new services, consultation to direct service programs and a variety of efforts to promote the best utilization of available resources. This discussion deals with six levels of planning and co-ordination: individual case, local, district, regional, Ministry of Health and interministry. The discussion focuses on the mechanisms for planning and co-ordination.

7.1 INDIVIDUAL CASE

Typically, the case management client is someone with multiple service needs in conjunction with reduced coping ability associated with chronic mental illness. The role of the case manager is to assist in ensuring continuity of care and of services for the individual client. It is estimated that approximately 0.35 to 1.0 per cent of those receiving mental health services require on-going case management.

Some hospital outpatient programs have been providing case management services to clients for years. In addition, there are several well-developed case management programs in place - most of them in Metro Toronto - which are worth noting.

Community Resources Consultants of Toronto (CRCT) is a non-profit agency with community rehabilitation workers (CRWs) seconded to four Metro psychiatric facilities. The CRWs undergo a special training program in Boston. Their first task is to identify, at the time of admission, those persons who are at high risk for further admissions. The definition of a high risk individual is someone who has had at least two previous psychiatric admissions, is unemployed and living alone. The CRW assists clients in identifying their physical, emotional and intellectual levels of functioning in order to determine the specific skill and environmental (for example, accommodation) deficits which need to be compensated for in order for the client to remain in the community after discharge. The CRW selects the appropriate resources to deal with these deficits, assists the client to use these resources, monitors and co-ordinates resource usage and provides on-going personal support at whatever level is required. The maximum caseload is 20 per CRW. This program receives funding from the Community Mental Health Services Program.

The ARCHWAY program operates out of Queen Street Mental Health Centre. Ten case managers have recently been hired; each will have a caseload of between 20 and 25 continuing care clients residing in the Parkdale area of Toronto. In addition to dealing with patients being discharged from hospitals, ARCHWAY will also have an active outreach focus through which workers identify clients already in the community who need case management services. The client's rehabilitation and aftercare needs are to be assessed, a rehabilitation plan is to be developed and on-going case management is provided as required.

Re Linc Services is a program of Mississauga General Hospital and deals only with the hospital's psychiatric patients who are about to be discharged. There are five case managers, each with 15 to 20 cases. The case managers have a variety of professional backgrounds: occupational therapy, social work and nursing. Re Linc also uses volunteer case-aides. The focus of Re Linc is, first, the supportive co-ordination and navigation of the client through community services; and, second, the teaching of basic coping skills for independent daily living in the community.

Central Toronto Youth Services (CTYS) has a somewhat different program which is directed specifically to young clients. Each case co-ordinator has up to 18 clients and sets up an individual program for each client. The case co-ordinator then purchases for the client those services which the client requires. In this respect, the case co-ordinator has more authority than the conventional case manager because of the ability to purchase services from agencies and individuals. The most frequently purchased service is one-to-one treatment; other services include accommodation, day treatment programs and specialized placements.

MCSS's Adult Protective Services Program, under the Developmental Services Act, provides case management services mainly for developmentally handicapped persons who have been deinstitutionalized and are now living in the community. The Adult Protective Services Worker (APSW) identifies, arranges for and monitors services for each individual client. In some areas of the northern regions, these workers also provide case management services to a number of ex-psychiatric patients.

There are also some other agencies across the province which provide case management services, although not within a designated case management program. Community Occupational Therapy Associates (COTA) in Toronto is an example of an agency involved in home care and aftercare where the resulting "product" often is case management. COTA works with both the physically and mentally disabled. The staff consists of trained occupational therapists and, where required, direct treatment services are purchased for the client. They work closely with MoH Home Care co-ordinators and hospital discharge planners to identify patients who would benefit from home care services, carry out assessments and prepare and implement a home care program for a period of four to six weeks. At the end of that period, the client can be transferred to COTA's long-term aftercare program. Clients are not assigned to COTA on a case management basis, but the effect of their work with the client, especially in linking them to required services, is case management. One of their major foci is psychogeriatrics.

Family Service Centres, funded by the United Way, are another example of service providers involved in case managing, although not formally designated as such. Another example is the public health nurse who often case manages as part of her work in the community. In some cases, public health nurses are involved in a more formal way in case management: for example, two public health nurses are located in Oakville-Trafalgar Memorial Hospital to help prepare discharge plans for patients about to be released and to assist in case management.

Except for the Metro Toronto region - where there are some specific case management programs in place - case management as a defined and specified program is not available to most chronic psychiatrically disabled persons across the province. Overall, there is a shortage of these programs across the province.

7.2 LOCAL

Planning and co-ordination functions at the local level are most needed in the larger urban centres where there are a multiplicity of agencies and services and relatively large client populations which need to make use of this multiplicity of services. The size of these client populations - and their variety of specialized needs - increases the need for the various agencies to plan and co-ordinate amongst themselves. Practically speaking, the planning which local bodies carry out involves identification of needs and gaps and the preparation of program proposals for presentation to the District Health Council. Inter-agency co-ordination, however, is much more concerned with the specific workings of the individual agencies: who will provide what services to which client groups, how these services will be provided and how they will be co-ordinated with related services.

Case management and co-ordination at the local level are essential, primarily because of that small group of mentally disabled persons who require on-going care and support. Since the multiplicity of required services are provided by numerous private and public organizations with separate administrative structures, some mechanism for inter-agency co- ordination is essential at the local level.

The Etobicoke Mental Health Services Agency (EMHSA) is made up of representatives from the local mental health agencies, hospitals, community groups and organizations. One of its objectives is to facilitate effective co- operation and co-ordination in service delivery for adults in Etobicoke. EMHSA also operates two mental health clinics. EMHSA is the first community agency funded by the Community Mental Health Services Program for inter-agency co-ordination of mental health service delivery.

The North York Inter-Agency Council (NYIAC) is a coalition of agencies, organizations and individuals concerned with social, health and educational services. Its mental health sub-committee provides a forum for mental health service providers to communicate and collaborate with each other. It is not involved, however, in formal co-ordinating or direct services.

Both EMHSA and NYIAC receive funding from the Community Mental Health Services Program. Membership is voluntary; however, it appears that local mental health providers are well represented in both instances.

7.3 DISTRICT

The trend in many countries with organized health systems is towards increased decentralization of the planning and operation of health services, along with a simultaneous effort to involve communities and consumers in the decision-making (Dixon, 1981:5). In the early 1970s, the Ministry of Health committed itself to decentralizing health care planning. District Health Councils (DHCs) are the Ministry's primary response to that commitment.

During the last ten years, 26 District Health Councils have been established which serve approximately 92 per cent of Ontario's population (Table III-26). A DHC consists of 15 to 19 volunteer members who represent consumers, providers and local government. Each Council operates with a small administrative staff. Some of the Council districts are co-terminous with municipal/regional government boundaries, some comprise a grouping of local government counties or municipalities, and some include unorganized municipalities. The non-Council areas include Hastings, Huron and Perth, Nipissing, Parry Sound and Muskoka, Prince Edward, Renfrew and Timiskaming. A steering committee has been appointed to consider the establishment of a Council in Parry Sound-Muskoka.(1)

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(1) In some areas not served by a Council, a Health and Social Services Planning Committee of the municipal regional council is responsible for non-institutional health care planning. In a few of these areas a voluntary Health Care Agencies Group also exists.

Table III-26

District Health Councils in Ontario*

Map Reference	DHC	Created	Size in Population	sq. miles
North West Region				
1	Kenora-Rainy River	1975	80,938	159,713
2	Thunder Bay	1974	158,294	42,281
North East Region				
3	Cochrane	1975	97,856	56,153
4	Algoma	1977	127,941	19,771
5	Manitoulin-Sudbury	1976	213,474	18,129
South West Region				
6	Grey-Bruce	1976	138,019	3,261
7	Lambton	1977	127,835	1,077
8	Essex County	1976	323,065	1,000
9	Kent County	1976	109,663	958
10	Thames Valley	1976	475,114	2,778
Central West Region				
11	Waterloo Region	1977	318,533	525
12	Brant County	1976	104,435	354
13	Haldimand-Norfolk	1981	91,369	1,124
14	Niagara	1975	377,659	715
15	Hamilton-Wentworth	1976	421,049	524
16	Halton	1976	254,408	370
17	Wellington-Dufferin	1976	173,843	1,602
Central East Region				
18	Peel	1977	442,500	473
19	Metropolitan Toronto	1980	2,092,931	242
20	Durham Region	1977	275,409	960
21	Haliburton, Kawartha and Pine Ridge	1975	227,618	5,124
Eastern Region				
22	Kingston, Frontenac and Lennox and Addington	1981	148,032	2,572
23	Lanark, Leeds and Grenville	1977	125,043	2,492
24	Ottawa-Carleton Regional	1974	546,922	1,064
25	Seaway Valley	1980	152,647	2,045

* Since this table was produced, a DHC in Simcoe County has been established in the Central East Region.

Source: Dixon, 1981:13.

There is wide variation in the size and characteristics of the DHCs. Some serve relatively small populations. Some are more sophisticated than others and are accustomed to dealing with a variety of mental health and related plannng issues and resources. Others are just beginning to feel their way.

In 1974, the Ministry established the basic terms of reference for District Health Councils. A Council's four major objectives are (Ontario Ministry of Health, 1974):

- to identify district health needs and to consider, consistent with provincial guidelines, alternative means of meeting these needs;
- to plan a comprehensive health care program and establish short term priorities that are consistent with long-term goals;
- to co-ordinate all health activities and ensure a balanced effective and economical service satisfactory to the people of the district;
- to work towards co-operation in the social development activities for the district.

The Councils are an advisory body and do not have executive powers for the allocation of funds or the administration of service agencies. In practice, however, they exercise a strong measure of control over the development of local programs through their review of the program proposals of all health agencies within their area of jurisdiction and through their recommendations on these proposals to the Minister. The delegated function of reviewing program proposals confers considerable informal authority on the Councils (Dixon, 1981:49), and, one of the strengths of the District Health Council program has been the direct channel of communication between the Council chairmen and the Minister of Health.

One of the difficulties faced by the Program has been the absence of full acceptance of the Council concept by the medical profession and the hospitals. There are, however, indications that this difficulty is being overcome as the Councils mature (Ontario Ministry of Health, 1983:xiv). The District Health Council system has proven itself to be viable and valuable, although some DHCs still have problems in role definition and in bringing the requisite level of sophistication and quality to their work, problems similar to those facing most volunteer organizations (ibid.).

A District Health Council's planning work applies both to institutional and to community health care. However, in the field of mental health services, the DHCs were not encouraged to concern themselves with the institutional aspects until mid-1982. At that time, the Minister of Health requested the DHCs to undertake a review of all adult mental health services in their communities, with particular reference to strengthening community mental health services such as housing, aftercare and other support services (Grossman, May 19, 1982:15). At that time, those DHCs which did not have a mental health sub-committee established one. The DHCs were subsequently instructed that the review should include an inventory of all institutional and community services associated with mental illness including, for example, provincial psychiatric hospitals, general hospital psychiatric units and Homes for Special Care beds. The final results of these studies are just beginning to be received by the Ministry (fall, 1983). Unfortunately, only general guidelines were provided to the DHCs for these reviews. Therefore, a comparison of the reports is likely to be difficult.

One of the main difficulties experienced by the DHCs generally in carrying out their health care planning mandate is that reliable and appropriate data are either unavailable or not readily accessible to them (Ontario Ministry of Health, 1983).

The DHCs terms of reference permit them to both plan and co-ordinate a comprehensive health care program. However, the DHCs differ in their understanding of their mandate with respect to co-ordination. A few DHCs understand co-ordination to include not only co-ordinating but also synchronizing the mental health care planning of all the agencies and institutions within their boundaries. Hamilton-Wentworth, Grey-Bruce and Lanark, Leeds and Grenville are examples of DHCs which have ensured that mechanisms were put in place for this detailed inter-agency co-ordination to take place effectively. Some DHCs, however, question whether they should become actively involved in co-ordinating the mental health services within their districts. Both the Metro Toronto and Durham DHCs have appointed committees to come forward with proposals regarding service co-ordination. There is a feeling in both these and other DHCs that the proper role of the DHC is to ensure that a co-ordinating mechanism is in place, but not to take responsibility for co-ordination.

7.4 REGIONAL

In 1975, six health planning regions were established: North West, North East, South West, Central West, Central East and East. In each Region an Area Planning Co-ordinator (APC) functions as the primary liaison officer between the Ministry and the District Health Councils in that region. In areas within the region where District Health Councils do not exist, the APC is the primary MoH contact with the local communities.

The APC also chairs the Area Health Services Committee. Although established in 1974, these committees suffered from varying definitions of mandate, with the result that they became inactive. In mid-1982, the terms of reference for these committees were revised and the committees restructured. Each committee's mandate is to provide an intra-Ministry forum for the sharing of information and the discussion of issues and planning strategies affecting the development of health care services within its particular health planning region.

In each of the regions, the Chairmen and the Executive Directors of the DHCs meet on a regular basis (at least quarterly) to exchange information. In some regions, the Chairmen and Executive Directors meet separately; in other regions they meet together. The Inter-Regional Chairman's Committee (IRC) meets approximately six times a year to discuss regional "boundary" issues while the full group of Council Chairmen and Executive Directors is convened once or twice every year.

In 1979, the District Health Councils' Research Program began and was sponsored by eight District Health Councils in Central West and North West Regions. The Program went through two stages; the first was collaborative research and the second collaborative planning. The general conclusion reached in the final report (March 1983) was that the Chairman's group was the most appropriate body to assume responsibility for regional planning. The Central West Region, as a result, has established the Central West Area DHCs' Planning Committee which is made up of the Executive Directors of the seven DHCs in the Central West Region.

7.5 MINISTRY OF HEALTH

Until 1972, the Ministry of Health possessed a Mental Health Division in which the activities of the Ministry related to mental health were co- ordinated. At that time the Division was disbanded as part of a comprehensive Ministry reorganization. The Mental Health Branch was established in late 1981, with institutions (PPHs) and adult community mental health programs brought together under one Assistant Deputy Minister. In 1982, the Mental Health Division was established as part of the decision to give priority to mental health.

There are still some anomalies in this reorganization: the Clarke Institute, the Royal Ottawa Hospital, Sudbury Algoma Hospital, the Addiction Research Foundation (because of its Clinical Institute which is regarded as a hospital) and general hospital psychiatric units continue to report to the Associate Deputy Minister, Institutional Health Services, despite their roles in mental health, although the Mental Health Division is responsible for policy development for the GHPUs.

The main vehicle for day-to-day intra-Ministry planning and co-ordination is the six Area Health Services Committees chaired by the Area Planning Co-ordinators.

7.6 INTERMINISTRY

As Chart AIII-1 (see Appendix A) indicates, responsibility for funding or providing a number of the services required by mental health clients falls within the jurisdiction of other ministries as well as of MoH. Co-operation and co-ordination among the various ministries has been recognized as necessary; but, inevitably each ministry developed its own organizational and delivery mechanisms, and its own priorities. So the need has developed to provide formalized mechanisms through which the requisite co-operation and co-ordination can take place. As a result, several interministry committees have been established:

- Interministry Committee on Housing and Support Services for Discharged Psychiatric Patients

  This committee consists of Assistant Deputy Ministers, or their representatives, from Health, MCSS, Municipal Affairs and Housing and the Provincial Secretariat for Social Development. The committee was established by the Cabinet Committee on Social Development in August 1981 and is, therefore, an 'official' body. Originally, this committee was intended to deal with the housing needs of ex-psychiatric patients in the Parkdale area of Metropolitan Toronto. Since then the committee has extended its mandate to deal with the situation province-wide and the member Ministries launched a number of co-ordinated initiatives: for example, MoH has provided increased funding for a variety of rehabilitation services, including accommodation, for ex-psychiatric patients; MMAH is considering a policy proposal to open up public housing to ex-psychiatric patients; MCSS expedited the review of long-term GWA recipients vis-a- vis FBA and is broadening its definition of "disabled" in some program areas to include the psychiatrically disabled.

- Triministry Project

  The committee to undertake the Triministry Project was established in 1980 with a four-year mandate and consists of representatives from Health, MCSS and Education. The committee's mandate is to assess every mentally retarded resident in the HSC and Extended Care Programs, and to develop individual program plans for each of the residents. The committee will have spent $18.8 million for the four years ending March 1984. Although programs for all the residents have not been developed, the project is currently under review and is awaiting a decision on additional funds for 1984/85 to complete its mandate.

- Interministry Committee on Children's Mental Health Services
  The committee, established in 1981 and with representation from Health and MCSS, was to identify problems and make recommendations with respect to mental health services for children. The committee surveyed the field of children's mental health services and reported in September 1982. One of the recommendations was that the committee be reconstituted at a more senior level and that it have a more focused agenda. These two recommendations have been accepted by both Ministries. The committee is now accountable to the Assistant Deputy Minister, Public and Mental Health, MoH and the Assistant Deputy Minister, Policy and Program Development Division, Ministry of Community and Social Services.

Until May 1982 these were the three major mechanisms for interministry planning and co-ordination. In May 1982, The Hon. Larry Grossman, then Minister of Health, announced that the MoH would be the 'lead Ministry' in all matters pertaining to adult mental health services (Grossman, May 29, 1982). The Minister defined this role by explaining that in those areas where the MoH does not have direct responsibility, such as housing and social services, it will ensure that the patients' non-medical needs are brought to the attention of the appropriate ministries, agencies, municipalities and federal government. There appears to be general agreement amongst the Ministries represented on the Interministry Committee on Housing and Support Services for Discharged Psychiatric Patients that Health is the appropriate provincial Ministry or body to assume this lead role.

The past two years or so have seen a considerable increase in the amount of interministry co-operation and co-ordination. Although a great deal remains to be done, it appears that at least some of the basic mechanisms are in place.

8.0 RESEARCH

8.1 FUNDING AND ORGANIZATIONS

In Ontario, the primary statutory mental health research granting body is the Ontario Mental Health Foundation. The Foundation's budget for 1981-82 was approximately $2 million. The Foundation has seen its role primarily as fostering the development of basic research. The area of basic rather than applied mental health research was judged by the Foundation to be in need of financial support for two reasons: 1) the difficulty in obtaining funds from the Medical Research Council of Canada for basic psychiatric research; and 2) the perception that the extramural program of the Ministry of Health was already funding projects in the area of program development, delivery of care and applied clinical research.

The relatively small amount of funds available to the OMHF has dictated that it concentrate its research support in the Health Sciences Centres. In 1981-82, the Foundation funded 23 new research grants, 17 on-going research grants, 4 major equipment requests, 20 new individual awards, 6 on-going individual awards and 6 educational associateship awards.

While only the OMHF receives research money for distribution, it is not the only body which receives funds for research in mental health from the Ministry of Health. Other major research bodies include the ARF and the Clarke Institute.

It is useful, first of all, to examine the distribution of research funds by the MoH and other sources to the health field generally (Table III-27). The table demonstrates that for the fiscal year 1982-83 the ARF received almost 21 per cent of all Ministry research funds, compared to about 4 per cent for the OMHF and 4 per cent for the Clarke.(1)

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(1) In Table III-27 and subsequent tables, the research expenditures of the OMHF and the Clarke are combined. Each institution spends about the same on research and, for all practical purposes, half the combined research expenditure can be attributed to each.

Table III-27

Estimated Ministry of Health Contributions to Medical and Health Research: 1982-83 ($000,000)

Program	Direct Funding	Indirect Funding	Total	%
Foundations:				
Addiction Research Foundation/ Clinical Institute	2.4	6.7	9.2	20.6
Ontario Mental Health Foundation/ Clarke Institute	1.9	1.9	3.8	8.5
Ontario Cancer & Treatment Research Foundation/Ontario Cancer Institute	3.2	5.4	8.6	19.4
Extramural Programs*				
- Revenue	8.3	-	8.3	18.6
- Lottery	2.3	-	2.3	5.2
Intramural Programs	-	6.1	6.1	13.7
Hospital Research				
- Hotel Costs	-	6.2	6.2	14.0
Total Research Expenditures	18.1	26.3	44.5	100%

*Includes: Health Care Systems Research; Public Health Research and Development; Health Research Personnel Development; Provincial Research (being phased out); Corporate Grants.

Source: Ministry of Health, Policy Analysis and Research Branch, January 1983.

It is also worth noting that the Ministry spends approximately 0.7 per cent of its total budget of $6.6 billion (1982/83 Estimates) on all forms of health research, of which mental health is only one component. By comparison, community mental health services in the U.S. are obliged to spend at least two per cent of their operating budgets on evaluation.

Table III-28 sets out total MoH transfers to the OMHF, the Clarke Institute, and the ARF for research, treatment and other activities. These figures indicate that of the total funds allocated to these institutions, 60 per cent goes to ARF and 40 per cent to the 'mental health' institutions. The proportion allocated for alcohol and drug abuse would be somewhat higher if the figures for The Donwood Institute were included.

Table III-28

The Statutory Foundations - Ministry of Health Transfers: 1982-83

	$	%
A.R.F.	26,753,400	59.6
O.M.H.F.	2,269,800	5.1
Clarke	15,852,653	35.3
	44,875,853	100.0

Source: Ministry of Health, Policy Analysis and Research Branch, August 1982.

Of the funds allocated to mental health, 87.5 per cent goes to the Clarke Institute which is a teaching hospital with a mandate for psychiatric research, education and treatment. The OMHF, which also has a broad mandate for mental health, receives 12.5 per cent of these funds for distribution to all research centres in the province including the Clarke.

Table III-29 sets out the expenditure patterns of the three mental health/addiction institutions. The table, admittedly two years out of date, indicates that of the total funds available for research to the three institutions, some 70 per cent was spent on addiction research. The balance was spent by the OMHF and the Clarke in approximately equal proportions. To keep these figures in perspective, one should recognize that the ARF is the institution in the province carrying out the most extensive research programs in addictions, while other institutions are involved in mental health research; consequently, these figures do not tell the whole story. Nonetheless, they do suggest that there is a substantial weighting of funds towards addiction-related research.

Table III-29

The Statutory Foundations - Expenditure Patterns: 1980-81

	A.R.F.		O.M.H.F./Clarke	
	%	$000,000	%	$000,000
Research	34.2	7.9	20.9	3.0
Treatment	21.1	4.9	71.2	10.2
Community Development	21.5	4.9	—	—
Education	23.2	5.3	7.9	1.1
	100.0	23.0	100.0	14.3

Source: Ministry of Health, Policy Analysis and Research Branch, August 1982.

A review of the various reports of these three institutions suggests that the allocation of their research monies is not highly congruent with Ministry of Health priorities. These three institutions have independent research mandates and by definition it is not necessary, or perhaps desirable, that their research programs be fully in phase with the Ministry's priorities on a given day. It is, however, striking that the incidence of congruence appears to be so low.

The Minister of Health stated in 1982: "...we must begin to look at the research grants that our Ministry dispenses on the one hand, and the identifiable list of serious problems and priorities that affect the operations of the health care system on the other - and we must begin to match the two" (Grossman, September 25, 1982). This policy does not seem unreasonable in the current economic situation and given the increasing demands upon mental health services in the province. The OMHF established a Task Force in 1983 to review the Foundation's research objectives and priorities. The final report of the Task Force is now completed and the Foundation is hoping to work with the MoH to develop a more balanced set of priorities for mental health research.

In the spring of 1983, the Minister of Health announced the establishment of the Health Research and Development Council of Ontario to establish priorities for health research, and to advise the Ministry on an annual health research expenditure of approximately $25 million. In addition, the research conducted by the statutory foundations - including the ARF and the OMHF - will be co-ordinated and assisted by the Council.

8.2 HEALTH SCIENCES CENTRES

A Health Sciences Centre is the health sciences complex on a university campus which includes, among other facilities, a teaching hospital(s) as an integral component. These Centres were envisaged as performing teaching, research, and service functions. Early in their development, four goals were identified for the Centres (Department of National Health and Welfare, 1969):

1. To produce its share of the health personnel needed;
2. To ensure adequate continuing education opportunities for both professional and auxiliary personnel;
3. To establish models of health care of high standard for its constituent region;
4. To conduct research of appropriate substance and diversity not only to advance knowledge in the fields of science essential to medicine but also to evaluate:
    - (a) Its own educational operations,
    - (b) The health needs of the community,
    - (c) The quality of care being rendered.

There are five Health Sciences Centres in Ontario: one each at the Universities of Ottawa, Western Ontario (London), Queen's (Kingston), Toronto and McMaster (Hamilton). They are funded through operating grants to the universities and receive additional funds for health sciences research from such bodies as the Medical Research Council and Health and Welfare Canada.

Most provincial psychiatric hospitals are associated with a Health Sciences Centre, although the nature of the relationship varies. Lakehead Psychiatric Hospital and Penetanguishene Mental Health Centre are not as yet formally lined with a Health Sciences Centre. Some general hospital psychiatric units are defined as affiliated teaching hospitals and, therefore, have a close relationship with a Health Sciences Centre. In general, the relationship between the various Health Sciences Centres and the PPHs needs to be clarified, formalized and strengthened.

During the late 1960s when regional health councils were being suggested, it was intended that the Health Sciences Centres would play a key role in their planning endeavours (ibid.). District Health Councils have tended not to be strongly linked with the Health Sciences Centres. However, Hamilton- Wentworth District Health Council has worked closely with the Faculty of Health Sciences at McMaster University for some time, and the Thames Valley District Health Council has worked with the University of Western Ontario.

Service, education and research are the three components on which a health care system are based. Traditionally, the Ministry has placed a great deal of emphasis on the delivery of health care services, while universities and their health sciences centres have emphasized research and education. Each has tended to ignore the other's concerns and priorities. Fortunately, both are now beginning to recognize the need for greater integration and co- ordination of the efforts being expended on each of the three components. The establishment by the Ministry of the Health Research and Development Council of Ontario is a response to that need. While the university health sciences centre is not a trade school, it must, as well as producing academics, train its professionals to be cognizant of the reality and responsibilities of working within the health care system. It must also work closely with the Ministry in shaping that health care system in response to new knowledge and in developing strategies for evaluating existing and new approaches. There are small signs that this is beginning to happen.

9.0 HUMAN RESOURCES

This report has referred frequently to the wide variety of professionals and paraprofessionals involved in the provision of mental health care services. The major categories include:

- General practitioners
- Nurses
- Social workers
- Psychologists
- Psychiatrists
- Occupational therapists
- Lay counsellors

To this group one must add volunteers who, although not certified professionals or paraprofessionals, contribute a host of skills and services to the mental health field.

This discussion on human resources should be treated as preliminary for several reasons. The field of manpower supply and need is a highly specialized and often contentious field. Also, there are no definitive standards with respect to manpower supply for mental health services to which one can turn for guidance. The Ministry of Health carried out a comprehensive review of health manpower a few years ago (Ontario Ministry of Health, 1980). But its comments on manpower requirements represent the opinions of consultants, professional groups, published materials and other sources and the report itself does not set out specific standards. Also, any discussion of manpower requirements must take into account the changing body of knowledge and the resultant changes in the roles and responsibilities of the participating disciplines. To the extent that these roles and responsibilities are altered, manpower requirements must also change.

The mandate for this study does not call for this kind of detailed examination. Consequently, what is attempted in this chapter is an overall picture of the manpower resources which are currently available to mental health, and an indication of the manpower issues which need to be considered in the short term to meet the needs of the next decade.

What the following analysis does not reflect is the relationships and links, or lack of them, among the various mental health professional categories. One observer recently noted a widening of the cracks within the mental health movement, including increasing disharmony between psychiatrists and other mental health professionals over who should do what and what are the best means for achieving mental health objectives (Leighton, 1982:18). One of his concluding comments is that social workers, nurses, psychologists and psychiatrists must sort out their competing theories and spheres of influence and move toward improved co-operation. Although the increasingly popular multidisciplinary team approach often achieves the necessary co-operation, the patient's need to know which professional has the overall responsibility for his treatment is often not given sufficient consideration.

One other general problem must be noted. Other than in the field of psychiatry, no standardized training exists for each of the other disciplines involved in providing mental health services. Curricula can and do vary considerably within the individual professions.

9.1 GENERAL PRACTITIONERS

It has been estimated that perhaps 75 per cent of all those persons seeking psychiatric treatment receive that treatment only from their general or family practitioner.

The figures (Table III-30) show a significantly uneven per capita distribution of general practitioners across the six regions. The significance of this unevenness has to be considered with caution. It may be that in some regions, in the north for example, a higher proportion of general practitioners are engaged in full-time direct clinical care and a smaller proportion in administration, teaching and research. Consequently, the figures may not reflect the actual availability of general practitioners for clinical work. Nonetheless, it does appear that the two northern regions are not as well provided for as the most heavily populated regions. It is also likely that the distribution within regions is uneven, but an intra-regional analysis has not been attempted to determine to what extent the larger urban centres are better served than the smaller centres and rural areas.

Table III-30

Distribution of General Practitioners by Region: 1982*

	Number	Per Capita
South West	1,197	1:1063
Central West	1,495	1:1133
Central East	4,244	1:861
East	1,405	1:844
North East	447	1:1305
North West	174	1:1358
Total	8,962	1:963

* Includes Family Practitioners. Per capita ratios based upon population figures for census year 1981.

Source: College of Physicians and Surgeons of Ontario, 1982.

9.2 NURSES

The MoH Health Manpower in Ontario study (1980:53) found that there was a shortage of nurses with training in certain clinical areas, including psychiatry. No estimate, however, was provided on the extent of this shortfall. As of February 1981, there were some 3,532 registered nurses reporting psychiatric care as their primary area of responsibility across all employment settings. This figure includes nurses working on a full-time (2,538), part-time, casual and seasonal basis. Of this total, some 2,219 registered nurses were employed in psychiatric hospitals, of whom 1,732 were employed on a full-time basis (Ministry of Health, Policy Analysis and Research Branch).

In 1981, there were also approximately 22,570 registered nursing assistants. Most of these were employed in hospitals, with nursing homes and homes for the aged as the second largest place of employment. Consequently, RNAs constitute an important manpower resource for any expansion of non- hospital residential alternatives. The Ministry of Health study (1980:58) concluded that if RNA staffing remains constant in hospitals, and the number of nursing home beds increases significantly throughout the 1980s, the demand for RNAs may exceed the supply.

One category which deserves particular attention is that of public health nurses because of their front-line position in the community. Table III-31 sets out the regional distribution of public health nurses. These figures show a reasonably even distribution of public health nurses across all six regions. The North East and East regions are somewhat better served than the others. One might expect that, given the shortage of other resources in the less well populated areas, the per capita ratio of public health nurses would be higher than it is.

Table III-31

Distribution of Public Health Nursing Staff by Region: 1982*

	Number of Nursing Staff	Per Capita**
South West	304	1:4187
Central West	374	1:4528
Central East	913	1:4002
East	324	1:3658
North East	169	1:3452
North West	62	1:3810
TOTAL	2146	1:4019

* Includes management and supervisory staff as well as public health nurses, R.N.s and R.N.A.s.

** Per capita ratios based on population figures for census year 1981.

Source: Public Health Branch, MoH, December 1982.

9.3 SOCIAL WORKERS

A professional social worker is one who has a minimum of a Bachelor of Social Work degree. The Ontario Association of Professional Social Workers estimates that perhaps 50 per cent of the professional social workers in the province are members of its association. As of June 1983 there were approximately 3,611 professional social workers on the membership list of the OAPSW. Based on the OAPSW estimates, there are approximately 7,200 professional social workers in the province.

Table III-32

Estimated Distribution of Professional Social Workers by Region: June 1983

Region	OAPSW Distribution	Estimated Distribution*	Estimated Per Capita Distribution by Region
South West	429	860	1:1480
Central West	530	1,060	1:1598
Central East	1,846	3,700	1:988
East	402	800	1:1482
North East	102	200	1:2917
North West	94	190	1:1243
Sub Total	3,403	6,810	1:1267**
Muskoka & Parry Sound (North East/ Central East)	24	50	
Non-branch (North)	184	370	
TOTAL	3,611	7,230***	

* Based on the assumption that OAPSW members represent approximately 50 per cent of the total number of professional social workers in a given region.

** Per capita ratios based upon 1981 census year population figures.

*** Estimated figures do not include community college graduates with social service diplomas.

Source: Ontario Association of Professional Social Workers Directory, June 1983.

This figure does not include the large number of persons with community college diplomas in social work who are working in the social work field but who are not considered to be "professional" social workers by the OAPSW.

Table III-32 sets out the distribution of OAPSW social workers by region insofar as it was possible to do so. To provide some indication of how many professional social workers there actually are, the number of OAPSW members in each region have been doubled and a per capita estimate on a regional basis calculated. In doing so, community college graduates with social services diplomas have not been taken into account. Consequently, the figures must be regarded as an underestimate of the actual resources available.

A 1976 analysis of OAPSW membership indicated that approximately 25 per cent of their membership is employed in "health facilities". There is no information on how many are working in the mental health field, although it is known that social workers are one of the largest single occupational groups employed in the provincial psychiatric hospitals (Table III-16).

9.4 PSYCHOLOGISTS

The Health Manpower in Ontario study (Ontario Ministry of Health, 1980) expressed some uncertainty about the total supply of psychologists. The Ontario Board of Examiners in Psychology Directory indicates there are 1,123 certified psychologists registered in Ontario in 1983, with a per capita ratio (1981 population) of 1:8,025. To be registered as a psychologist, the individual requires a doctorate plus one year of post-doctoral supervised professional experience. Interestingly, about one-third of the new registrants each year come from the United States.

It is estimated that about half of the registered psychologists are involved in private fee-for-service practice on a full- or part-time basis. Another approximately 30 per cent are employed with funds derived from the Ministry of Health (Ontario Ministry of Health, 1980:131).

Table III-33 shows the per capita distribution of the psychologists by region. The typical pattern emerges. The highest proportion of psychologists are located in the southern, more heavily populated regions, while the less populated regions are less well served. This maldistribution is heightened by the tendency within each region for most of the psychologists to be located in one, or perhaps two, urban centres.

Table III-33

Distribution of Registered Psychologists by Region: January 1983

	Number of Certified Psychologists	Per Capita*	Number in Major Centres	
South West	178	1:7,150	London	102
			Windsor	36
Central West	132	1:12,830	Burlington/Hamilton	41
			Kitchener/Waterloo	36
Central East	561	1:6,513	Toronto	444
East	212	1:5,590	Ottawa	131
			Kingston	41
North East	25	1:23,334	Sudbury	11
North West	15	1:15,747		12
TOTAL	1,123	1:7,680		854

* Per capita ratios based upon population figures for census year 1981.

Source: Ontario Board of Examiners in Psychology Directory, 1983.

9.5 PSYCHIATRISTS

Psychiatry is the only profession working with the mentally ill which has a nationally defined body of knowledge and skills, including psychotherapy, a code of professional ethics and standards established by a single qualifying examination. By law, psychiatrists as registered physicians have the authority to prescribe medication, admit to hospital and sign certificates requiring involuntary containment for treatment.

There is a working hypothesis that there should be one psychiatrist for every 10,000 population. However, this is based upon opinion, not validated by assessments of need or demand "and there is no evidence that this target has other than consensual validity" (Cleghorn et al, 1982:618).

The per capita distributions (Table III-34) indicate serious inequalities among the various regions, particularly in the north. Also, it is likely that intra- regional differences are considerable. A 1981 MoH analysis found that the overwhelming majority of psychiatrists reside in the five cities containing the University teaching centres. These per capita figures are also inflated because a large number of psychiatrists teach, do research and administration on either a full- or part-time basis in addition to providing direct patient care.

Table III-34

Distribution of Psychiatrists by Region: 1982*

	Number	Per Capita
South West	110	1:11571
Central West	138	1:12272
Central East	557	1:6560
East	211	1:5617
North East	13	1:44874
North West	9	1:26245
TOTAL	1,038	1:8309

* Per capita ratios based upon population figures for census year 1981.

Source: College of Physicians and Surgeons of Ontario, 1982.

Both the MoH Health Manpower in Ontario study (1980) and the Cleghorn et al study (1982:620) indentify specific areas of psychiatry where there are quantifiable shortages (figures apply to 1980):

- Child Psychiatry: an additional 150 required to meet estimated need for 300 for the province.
- Geriatric Psychiatry: few psychiatrists are working in this field. It is estimated that an additional 34 are required to bring the number up to 56 only for the major urban centres.
- Forensic Psychiatry: 66 positions exist - an additional 44 are needed to fill only those institutional positions now open.

- Mental Retardation: 12 psychiatrists are identified as working in this field, and an estimated 21 additional psychiatrists are required to fill the existing shortfall in institutions and community services.

In addition, as of January 1982, the MoH's Committee for the Recruitment of Psychiatrists identified 21 vacancies amongst the 155 positions for psychiatrists in the provincial psychiatric hospitals. Although this represents a 14 per cent vacancy rate overall, in the more geographically isolated hospitals - North Bay, Lakehead, Brockville and Penetang - the vacancy rate is about 47 per cent (MoH, April 29, 1982). The factors associated with this vacancy rate are discussed in the section on recruitment in the PPHs.

It is worth noting that the Cleghorn et al study (1982) refers to the possibility of a shortfall in psychiatrists over the coming years, in addition to the existing identified shortfalls. Although postgraduate enrollment in psychiatry is about 250 (1980), because of attrition and other factors, the estimated supply of new psychiatrists in Ontario is estimated at about 24 annually. The Cleghorn et al study (1982:618) found that the mean age of Ontario psychiatrists was about 47 years. The study concluded that by 1986 there will be an increase in the rate of attrition of psychiatrists through retirement at the same time as the demand for services by the high utilizer group - young middle age - will increase, and that this attrition of psychiatrists will continue through to 1995. Their demographic analysis found that there is not a large group of younger psychiatrists available to move into senior positions.

9.6 OTHERS

There are several other important providers of mental health services about whom there is no detailed information available. Heading the list are occupational therapists. Occupational therapists are health care professionals with expertise in analysing and evaluating function and functional limitations in persons with physical, emotional, developmental or learning disabilities. Goals include restoration of emotional, social and psychological functions through vocational and recreational skills training.

The exact number of practicing occupational therapists is unknown since membership in both the Canadian and the Ontario Associations of Occupational Therapists is voluntary. The MoH Health Manpower in Ontario study (1980:60) estimated that there were 1,200 occupational therapists in the province, giving a per capita ratio of 1:7193. The study included a report from the Ontario Hospital Association that one of the highest vacancy rates in hospitals is for occupational therapists. However, a 1983 survey of health facilities of all types found that the vacancy rates for occupational therapists had dropped 50 per cent or more in the four southern regions since December 1980 (MoH, Policy Analysis and Research Branch). In the two northern regions, vacancy rates are running at about 25 per cent.

Figures are not available on the number of occupational therapists working in psychiatric facilities or in the mental health field generally. Their training and the work of Community Occupational Therapy Associates in Toronto suggest, however, that there is considerable potential for occupational therapists in the mental health field.

Another category is that of lay counsellors. Information is not available on the number of lay counsellors, the kinds of counselling they provide, their training, or their fees. Anecdotal evidence suggests that there is a substantial number of them across the province, particularly in the larger cities, that their training is highly variable, and that a range of "therapies" is used.

A number of mental health agency volunteers are also involved in various forms of counselling. They differ from lay counsellors in that they tend to carry out their counselling activities within the context, and under the supervision, of a recognized community mental health agency, such as the various branches of the Canadian Mental Health Association. There is another form of lay counselling which has grown rapidly in the past few years. This counselling is provided by the "self-help" groups - groups made up of people who have experienced or are experiencing mental health problems. Some of these groups also include families and friends.

All these lay individuals and groups constitute a potentially valuable manpower pool for mental health services. One must acknowledge, however, there is little information about who they are, the bodies of knowledge from which they work, the types of counselling or therapies which they carry out, their standards of practice or their ethics.

Perhaps the single most important finding arising out of the discussion above pertains not to the total number of professionals in any given health discipline, but to their distribution. This distribution across the six health planning regions on a per capita basis is highly uneven with the result that several parts of the province are underserviced. The North East, North West and Central West regions are the regions which are consistently the least well serviced by most types of mental health professionals. It has been, and continues to be, difficult to attract these professionals, particularly psychiatrists, to these areas. Psychiatrists are discouraged from practicing in the more remote parts of the province for several reasons including: 1) professional isolation, including difficulty in obtaining access to professional development opportunities and 2) overwhelming service demand. In addition, most training programs do not equip the psychiatrist to take on the practice style that is required in sparsely populated areas.

The Ministry of Health is attempting to redress the problem through its Underserviced Area Program which provides tax-free incentive grants to encourage health professionals to establish or join practices in underserviced areas. There were, as of September 1983, 174 communities designated as "underserviced", most of them in the north. Most of the professionals recruited to date through the Program are general practitioners (over 100). Forty-eight specialists, including 17 psychiatrists, have also been recruited. Twelve of the seventeen psychiatrists were recruited between January and September 1983. This constitutes a considerable achievement.

In addition, several southern universities and hospitals provide visiting psychiatrists to communities in the north. Doctors from Homewood Sanitarium (Guelph) visit Cochrane every six weeks. A psychiatrist from McMaster University travels to Northwestern Ontario on a monthly basis and provides service to several communities. The University of Toronto's Department of Psychiatry provides psychiatrists for a few days each month to visit numerous Indian communities in the vicinity of Sioux Lookout in northwestern Ontario.

University of Western Ontario's Northern Outreach Program has identified hospitals in Timmins, North Bay and Sudbury as regional affiliated teaching units. A number of physicians have been recruited for these centres and have received teaching appointments at that University. In addition, for these centres, the Program has, with funds from both MoH and MCSS, recruited a psychiatrist to practice in Terrace Bay and also to provide service to other general hospitals along the north shore of Lake Superior.

The use of appropriate interactive communication technology can also contribute to a solution of the servicing problem facing sparsely populated areas. In late 1980 the Woodstock General Hospital and the University Hospital's Departments of Psychiatry as teaching units of the University of Western Ontario were the initiators of a two-way audio-visual microwave link. The project, funded by the then Psychiatric Hospitals Branch of the MoH, has had the effect of attracting three psychiatrists to Woodstock, which has, in turn, reduced the number of referrals to London hospitals.

In May 1983, the Ministry of Health took the first step towards establishing a telehealth network in northwestern Ontario. A corporation will be formed to plan and co-ordinate telehealth activities in this health planning region.

Geography is not the only barrier to access to mental health services. Language constitutes another. The Dubois Commission Report (1976) and the Ontario Council of Health's Agenda for Action report (1979) identified the need for more French-language services in the Ontario health care system generally and in the mental health care system specifically. In early 1983, the MoH appointed a University of Ottawa psychiatrist as a consultant to co-ordinate French-language mental health services in northeastern and eastern Ontario. He is responsible for the recruitment of Francophone psychiatrists and to consult with hospitals in these two regions regarding the psychiatric services and programs required for their populations.

In addition, a French-language psychiatric services program has been established for the districts of Sudbury, Cochrane and Nipissing through an arrangement between the Departments of Psychiatry at the University of Western Ontario and McGill University. Six bilingual psychiatrists from McGill with cross appointments at the University of Western Ontario and North Bay Psychiatric Hospital provide consultation for two days each month to mental health clinics and GHPUs in Timmins, Sudbury, North Bay, Sturgeon Falls and Mattawa. In addition, these psychiatrists are on call by telephone the remainder of the time for consultation.

These are valuable initiatives to overcome geographic and language barriers to access to mental health services, but much remains to be done.

SECTION IV

ISSUES AND RECOMMENDATIONS

1.0 INTRODUCTION

> ".....as with any enormously complex situation, there is temptation to oversimplify the problem-solving process. The various components of the health care delivery system are highly interdependent and there is danger in attempting specific correction in one area for fear of creating new inequity or new imbalance in another."
>
> Report of the Joint Advisory Committee of the
> Government of Ontario and the Ontario Medical
> Association on Methods to Control Health Care
> Costs (1977:2)

In the previous section of this Discussion Paper, the existing organization and delivery of mental health care services and the basic issues were described. In this section, the issues are summarized and possible courses of action are recommended.

As we look to the next ten years in mental health care in Ontario, the first question we have to ask is how much will be required? It is useful to review the various estimates. Goldberg and Huxley (1980) calculate the morbidity rate at 250/1000 or 25 per cent; this translates into approximately 2.1 million Ontario residents, and covers the range of mental health conditions from the minor, transitory episodes of distress and dissatisfaction to the most severe and durable mental illnesses. Cleghorn et al (1982) estimate that in any given year at least 15 per cent of the population, or about 1.2 million residents in Ontario, suffer from a diagnosable mental disorder.

Based on these estimates, and applying the Saskatchewan data (Schmitz et al, 1979) on the role of the general practitioner in the delivery of mental health services to Ontario, it is probable that about eight per cent or more of Ontario residents, say 700,000 people, received medical services for a psychiatric diagnosis this past year, that three-quarters of them were treated by a general practitioner only, and that about half of them had short-term, relatively minor mental health problems.

Within these overall estimates of mental health service needs, however, there are three overlapping groups about which one can develop firmer estimates. The first consists of the "baby boom" population which has begun to move into the 25 to 45 year age category. This is the category which, historically, has made the heaviest use of psychiatric facilities. According to one analysis, the middle-aging of this group translates into a 50 per cent increase in psychiatric admissions by 1996 - assuming current psychiatric hospital admission rates remain constant.(1) To this should be added the effects of continuing unemployment which will likely place additional pressure on the demand for mental health services.

The second group are the elderly. The "greying" of the population increases the need for psychogeriatric services. Currently, there are about 886,700 persons in Ontario who are 65 years of age or older. By 2002, that figure will increase to about 1.38 million. The prevalence of diagnosable primary or secondary psychiatric disorder in this elderly population is somewhere between 10 per cent and 25 per cent, depending upon definition. That translates into somewhere between 88,600 and 220,000 elderly people in 1981 with psychiatric disorders.

The situation with respect to the growth in the elderly population is serious not just with respect to their requirements for psychiatric services, but also with respect to rehabilitation and maintenance services, especially accommodation. The numbers of persons in the 85 years and older ("old-old") category is increasing and may well double in the next 20 to 25 years. National statistics indicate that this group already absorbs more than a third of all available beds in homes for the aged, nursing homes and similar facilities; the situation in Ontario is likely comparable. The psychiatrically disabled elderly are in competition for accommodation with those elderly who are not disabled but who require supportive accommodation, as well as with those elderly who are only physically disabled. It is estimated that some 35 per cent of elderly Canadians are physically disabled and require some form of supportive accommodation (Medicus Canada, 1982). Also, the increasing number of beds being used by the old-old leaves less available for the young-old (65 to 85 years), and even less for the psychiatrically disabled elderly.

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(1) Data and analysis provided by Dr. Barrie Humphrey, McMaster University.

The third group consists of the chronically mentally ill. It has been estimated that from 0.35 per cent to 1.0 per cent of the population suffer from long-term psychosocial disabilities associated with reduced competence attendant upon their mental illness: schizophrenia and affective disorders are the major contributors to this chronically mentally ill population. This translates into 30,000 to 86,000 people who, in 1981, required continuing inpatient or outpatient treatment along with a range of support services.

These three groups overlap - for example, the estimates of the chronically mentally ill include some persons from both the middle-aged and the elderly category. Nonetheless, the numbers are sobering and reinforce the need for priorities to be established for the allocation of government funds.

Any discussion of mental health needs must recognize that there will always be mentally ill persons who cannot be helped. Those with personality disorders have proven to be particularly intractable; often the best we can do is to attempt to protect society from the more deviant and them from themselves. There will also always be people who refuse to be helped.

It is unrealistic to expect there will be a substantial increase in the proportion of Ministry of Health funds allocated to mental health services. Expenditures by the Ministry of Health on mental health services absorb about 10 per cent of its total budget, including OHIP fees to general practitioners, psychiatrists and other physicians. This proportion may increase by a point or two, but we have to assume that there will be no major change, given the enormous pressures for services the Ministry faces in other sectors of health care. Similarly, the Ministry is unlikely to receive a massive infusion of additional funds from Treasury, given current economic conditions. Therefore, it is crucial that we make the best possible use of the resources we have in working towards achieving the longer-term goals.

The overall thrust of the recommendations in this paper is towards achieving two fundamental goals, a balanced and comprehensive mental health care system and the separation of treatment from accommodation.

Balanced mental health care system. "Balanced" means a distribution of resources so that the required range of services is as available to persons who do not need an inpatient setting for treatment, care and support, as it is to persons who do need an inpatient setting. It is important to strive towards a mental health care system which emphasizes non-institutionalization, which directs energy and resources towards providing services outside the hospital so that hospitalization occurs only when dictated by treatment or behavioural needs.

Separation of Treatment from Accommodation. We should not be admitting people to hospital unless they need an inpatient setting for specific treatment or for behavioural problems. This goal has already been accomplished to some considerable degree through the extensive deinstitutionalization of provincial psychiatric hospital patients over the past 15 years or so. However, the early period of deinstitutionalization was not accompanied by a sufficient emphasis upon the provision of alternative support services, including accommodation, with the result that many patients discharged into the community experienced difficulty. Despite the marked improvement in the availability of these services in the last two years, we have a lot of catching up to do.

It must also be recognized that hospitalization will continue to be necessary for some number of mentally ill persons, both for short and longer periods of time in an inpatient setting because of specific treatment needs. Hospitalization will also continue to be necessary for those who must be cared for in a protective setting.

An essential corollary of deinstitutionalization and non-institutionalization is the provision of alternative settings for treatment and care in the least restrictive and disruptive settings, settings which are as close to the patient's or client's home as is practical.

Several issues need to be resolved in order that we can achieve these goals. They can be grouped under three major headings:

1. Planning and Co-ordination
2. Continuity of Care
3. Human Resources

There are other issues which do not fall easily into any of the above headings and which are dealt with separately. These include: the provincial psychiatric hospitals, their roles and future, the statutory foundations, specialized services for the forensic, the developmentally handicapped and the psychogeriatric populations, and prevention.

At least one important issue is not dealt with in this Discussion Paper - the Mental Health Act. The Act was revised to incorporate stricter criteria for the involuntary commitment of mentally ill persons to hospitals. The principle upon which the revisions were based - to protect the rights of persons suffering from mental illness - is a sound one. There is, however, the right - some might say the obligation - of the family and society to ensure that an individual with impaired judgement due to a mental illness receives adequate treatment. As matters stand now, families are unable to ensure that a member of the family receives such treatment unless that individual presents an imminent physical danger to himself or to others. This means that some number of seriously mentally ill people are not being treated. While the absolute numbers of individuals involved may not be large, they are nonetheless, significant and the consequences are certainly important to the family and to the individuals concerned. This is the old question of the balance of rights. This discussion leads one inevitably to possible revisions of the Mental Health Act, a discussion which is beyond the terms of reference of this paper. There is no easy solution to this problem. At the same time, the problem must be recognized and given further study.

Few of the individual recommendations which follow could be described as "dramatic". In many cases, the focus is on issues such as co-ordinating mechanisms, reporting procedures and integration. The attentive reader will realize that changes in what might be considered to be mundane areas can have wide-ranging and long-term beneficial effects on the provision of mental health services. In addition, the ideal is not always achievable. There are always constraints. The recommendations are directed towards what is feasible within these constraints.

The long-term costs associated with implementing a comprehensive and balanced mental health service system which emphasizes non-institutionalization are difficult to calculate. It is certainly possible that these costs will be greater than those of a mental health service system which relies heavily on institutionalization. Over the coming years we, as taxpayers, may be faced with choosing between what is preferrable and what is affordable. All of which underlines further the absolute necessity of setting priorities and making the best use of the available resources.

Much has already been accomplished in the past two years or so to improve mental health services in Ontario, and more can and must be accomplished.

2.0 PLANNING AND CO-ORDINATION

The Agenda for Action report (1979) identified planning and co-ordination as one of the major issues confronting mental health care in Ontario. Since that time, the Ministry of Health has undertaken a number of steps to redress the situation. These initiatives have been discussed at length in the previous section, and they are taken into account in the recommendations which follow.

"Planning" and "co-ordination" are terms to which a variety of meanings can be attached. For the purposes of this discussion, "planning" is taken to include:

(1) Objectives: A set of decisions as to what a balanced mental health care service system should consist of in order to meet the identified needs of the population it is to serve;

(2) Process: The steps necessary to achieve the objectives;

(3) Priorities: The order in which the objectives are to be achieved.

Planning must be sufficiently flexible to allow us to accommodate changing circumstances, and yet be sufficiently firm in order to ensure that the objectives of the plan are not lost or obscured.

"Co-ordination" consists of establishing a set of mechanisms to ensure that the services which are put in place are used in the most effective manner.

The overall purpose of planning and co-ordination is to enable us to identify and respond to community needs, to make the most efficient use of available human and other resources and to improve our ability to evaluate the services provided by these resources.

The basic requirements for effective planning and co-ordination can be met largely by using those mechanisms and resources already in place. The Ministry of Health has six health planning regions; within each region there are from two to seven District Health Councils each of which encompasses one or more municipalities; and at the local level there are a variety of agencies which deliver mental health services. The purpose of this section is to indicate objectives or basic mental health program components which should be provided at each of these levels, and to suggest ways in which to strengthen and integrate existing planning and co-ordinating mechanisms.

Implicit in effective planning is the clear definition of roles and responsibilities: who is to do what? To this end, a three-level hierarchy of services is proposed: essential, desirable and elective. The first task is to ensure that each health planning level has at least all the services designated as essential for that level. Desirable services are programs involving research and service development to meet the needs of persons suffering from the less disabling forms of mental illness. Elective services are directed to particular needs in a district or region pertaining, for example, to the problems of a particular cultural group or to a local phenomenon such as high unemployment. Only when it is demonstrated that all the designated essential services are in place should funds be allocated for desirable or elective services.

In the interim report, the concept of the "pivotal hospital" was put forward for discussion. After extensive consultation across the province, the need for a reassessment of this concept became obvious. The hub of the concept is that psychiatric and other mental health services be in place at the most suitable level - local, district, regional or provincial - and that these essential services be available at designated sites in sufficient number and in a geographical distribution adequate to meet the needs of the populations they are intended to serve. The actual organization of the delivery of these essential services is a matter to be decided upon at the appropriate level of planning and co-ordination.

There are a number of ways, for example, in which the delivery of psychiatric services at the district level can be organized. In the Grey-Bruce District, the District Health Council and Owen Sound General and Marine Hospital have initiated a pivotal hospital pilot project. As part of the project, all persons from the Grey-Bruce area requiring psychiatric inpatient, outpatient, or day care treatment are referred to Owen Sound General and Marine Hospital. A psychiatric crisis service is being developed at the hospital and the hospital is working directly with local agencies to develop new community mental health programs, particularly in the area of housing programs. The regional psychiatric hospital has seconded staff to the General Hospital to assist in these endeavours, and psychiatric patients may be discharged directly to the Homes for Special Care Program. Informal reports suggest the pilot project is working well; one of the results appears to be a reduced utilization of inpatient treatment services. This model may be applicable in other underserviced areas. An approach for multiple hospital centres is that used in Hamilton where several hospitals have avoided duplication by allocating amongst themselves the responsibility for providing specific components of essential services.

2.1 DISTRIBUTION OF ESSENTIAL MENTAL HEALTH SERVICES

The following is the proposed distribution of essential mental health services at the provincial, regional, district, local and individual case levels. The number of such services at each level, their geographical distribution and their organization are matters to be decided by the responsible planning and co-ordinating body. In general, high prevalence and/or less specialized mental health service needs are to be met at the local level, while low prevalence and/or more specialized mental health services needs are to be met at the provincial level. If these essential services are provided at each of the various levels - provincial, regional, district and local - then the basic elements of a balanced mental health service system will be largely in place.

Essential services at each level include:

> Local - Case management services and likely some number of district level essential services.

District - The essential services required of Schedule 1 psychiatric facilities, including inpatient, outpatient, day care, crisis service with the capability for short-term safely-keep, and consultation to agencies and the community;

Specialized assessment, diagnosis and short-term treatment services including psychogeriatric, addictions, and disturbed mentally retarded (the latter may be provided at the regional level rather than the district level depending on population requirements);

Rehabilitation and maintenance services, including accommodation, life-skills training, educational and vocational rehabilitation, social and recreational and case management.

Regional - Medium secure forensic, inpatient chronic care services.

Provincial - Maximum secure forensic, long-term maximum secure treatment for seriously disturbed children and adolescents; other comparable services as identified.

RECOMMENDATION

- **ESTABLISH ESSENTIAL MENTAL HEALTH SERVICES AT THE LOCAL, DISTRICT, REGIONAL AND PROVINCIAL LEVELS.**

2.2 LEVELS OF PLANNING AND CO-ORDINATION

The following recommendations deal with each of the levels at which planning and co-ordination must be ensured. The objectives of the recommendations in the following section are integrated planning and close co-ordination both at each level and among levels, and a formal and structured relationship between planning and co-ordination at each level.

2.2.1 Individual Case

The ultimate objective of any mental health service system is the delivery of the necessary resources to the person in need as expeditiously and effectively as possible. The vast majority of persons in need of mental health services can find the resources they require by themselves or with some modicum of short-term assistance. However, between 0.35 per cent and 1.0 per cent of the population have reduced competency attendant upon a mental illness and require continuing assistance in obtaining the necessary services which they require. This population is at risk and, if it does not receive the appropriate treatment and support services in the community, is likely to require admission or readmission to a psychiatric facility.

This is the target population for the case manager. The client's need for a case manager is dictated not solely by the nature and severity of the mental illness, but also by the extent of reduced coping ability. The functions of a case manager include:

- To assist in identifying those individuals both in the hospital and in the community who require management;
- To assist in assessing the client's needs for community living, in identifying those resources necessary to meet those needs and in preparing a client rehabilitation or maintenance plan;
- To act as the client's agent on an on-going basis in obtaining access to the necessary resources by liaising with the different agencies to ensure co-ordination of service delivery, including treatment, accommodation and other rehabilitation or maintenance services.

These functions require that case managers belong to an agency which has a formal affiliation with psychiatric services for consultation and backup.

Some case management is done informally; public health nurses, for example, often carry out case management as part of their role. There are also several designated case management programs such as ARCHWAY, Community Resources Consultants, ReLinc and, less formally, Community Occupational Therapy Associates. These tend to be concentrated in the Metro Toronto area. The only province-wide model of case management is the Adult Protective Services Worker Program of the Ministry of Community and Social Services which serves developmentally handicapped persons who have been deinstitutionalized.

Personnel with skills to undertake case management are available among existing manpower resources including public health nurses, social workers and occupational therapists. Because of their health science training, particular attention should be given to the use of public health nurses as case managers in underserviced areas of the province where other medical resources are less available. Possibilities also exist for the purchase of services from the Ministry of Community and Social Services' Adult Protective Service Workers in the underserviced areas. Provincial psychiatric hospital front-line staff provide another potential resource for the case management of at-risk patients/clients. There is a need for more case management training programs with defined criteria and standards; persons successfully completing these accepted programs would be recognized as qualifying to provide case management services.

RECOMMENDATION

o **CASE MANAGEMENT SERVICES BE AVAILABLE TO MENTALLY ILL PERSONS IDENTIFIED AS BEING AT-RISK.**

2.2.2 Local

Local mental health agencies are required to submit proposals for Community Mental Health Services Program funding to their District Health Council for review and priorization.

RECOMMENDATION

o **PROGRAM PROPOSALS FROM LOCAL AGENCIES DEMONSTRATE ADEQUATE CO-ORDINATION WITH EXISTING LOCAL AND DISTRICT PRIORITIES, PROGRAMS AND SERVICES.**

2.2.3 District

The District Health Council constitutes the linch pin of the Ministry of Health's decentralized health care planning process. Each District Health Council is required to assess health needs and trends in its district; to prepare a comprehensive plan with short-term and long-term priorities to meet the objectives of the plan; to co-ordinate all health care planning activities in the district; and to work towards co-operation with the social development activities in the district. Acting on a request from the Minister of Health in the spring of 1982, each District Health Council is either in the process of preparing a mental health plan or has recently completed one.

Each District Health Council has a mental health committee or equivalent to deal specifically with mental health planning and co-ordination in its district. The composition of the mental health committees varies from Council to Council, and it is important to ensure consistent and comprehensive representation. There is also considerable variation among the mental health plans being submitted by the various Councils.

Representation on the Committee should include: Ministry of Health-funded service providers, volunteer organizations and the Addiction Research Foundation if it is active in the district; Ministry of Community and Social Services; Ministry of Tourism and Recreation; Community Advisory Board and clinical staff from the provincial psychiatric hospital which serves the district; clinical staff from the district general hospital psychiatric units; district municipalities; Ministry of Municipal Affairs and Housing or Ontario Housing Corporation or local housing authorities; consumers.

The mandate of the District Health Councils does not authorize them to allocate responsibility to any particular agency or group of agencies to develop new services or to expand existing services. With respect to these matters, the District Health Council must wait upon the willingness of local agencies to submit proposals which it will then priorize in keeping with its mental health services plan. This largely reactive role is not congruent with the needs of the current situation. Even if the District Health Council cannot allocate responsibility, it can, through a structured planning review process, encourage service providers in the district to discuss how to co-ordinate their existing services, reduce unnecessary overlaps and establish new or expanded services as required. Although the responsibility for allocating funds to programs must continue to reside with the Ministry of Health, the District Health Council plays the important role of identifying needs, reviewing and priorizing mental health program proposals from its area and encouraging co-ordination and integration of these programs.

Criteria or guidelines are required for the preparation of district mental health plans. These criteria should include regular, formal plan and priority review procedures. The plans themselves should be distributed to all local agencies so that they can incorporate the Council's planning into their own.

In turn, the Councils should require that all mental health program proposals contain a comprehensive and detailed description of the needs which the program is to meet, the other programs with which it will be co-ordinated, the procedures through which co-ordination will occur, and confirmation from the affected agencies of this agreement to these proposed arrangements.

The Ministry of Health carries out annual evaluations of all programs funded by Community Mental Health Services. The Ministry should ensure that the Councils are informed of these results speedily and in a consistent form. As well, there are mental health programs not funded by Community Mental Health Services. In these instances, the program sponsor should undertake, as part of the program proposal, to carry out an annual program evaluation and to report the results to the Council.

RECOMMENDATIONS

- **A DISTRICT HEALTH COUNCIL OR ITS EQUIVALENT BE ESTABLISHED IN ALL AREAS OF THE PROVINCE.**
- **EACH DISTRICT HEALTH COUNCIL ESTABLISH A MENTAL HEALTH CARE PLANNING AND CO-ORDINATING COMMITTEE.**

2.2.4 Region

The Ministry of Health health planning region is the smallest area that incorporates all the essential components of a balanced mental health service system, except for those highly specialized services which can be available only at the provincial level because of low prevalence. Currently, there is no body at this level whose primary focus is the planning and co-ordination of mental health services.

The objective is to establish such a committee which would have as its mandate: identifying regional objectives, establishing regional priorities, evaluating progress towards the achievement of these, and providing a forum for information exchange among the District Health Councils' mental health committees.

Such a committee might consist of the chairpersons of the District Health Council mental health committees within the region and representatives from those areas in the region which have not yet established District Health Councils; representatives from the Ministry of Community and Social Services, Ministry of Municipal Affairs and Housing, Ministry of Correctional Services, Ministry of the Attorney General, and other Ministries as appropriate; a senior representative from the Health Sciences Centre within or associated with the region; Ministry of Health Area Planning Co-ordinator; a representative from the Planning Branch, Mental Health Division.

The Area Planning Co-ordinator could act as executive secretary of the Committee with the chair held on a rotating basis by chairpersons of the various District Health Councils' mental health committees.

Each District Health Council would report in a formal way to the Regional Mental Health Committee not less than once a year with respect to its plans, priorities and work in the mental health field; the Regional Mental Health Committees, in turn, would report in writing at least annually to the Ministry of Health.

RECOMMENDATION

- **A REGIONAL MENTAL HEALTH COMMITTEE BE ESTABLISHED IN EACH OF THE SIX HEALTH PLANNING REGIONS.**

2.2.5 Ministry of Health

The Ministry's role in mental health care planning is to develop provincial priorities, to set standards, and to evaluate the services being delivered in the context of these priorities and standards. The responsibility must remain with the Ministry for ensuring, as the agent of the people, that local planning leads to the adequate provision of essential mental health services to all residents across the province. Given this responsibility, the Ministry must remain the final arbiter regarding regional, district and local service provision.

There are several planning and co-ordination issues within the Ministry of Health which need to be resolved.

One is the division of responsibility within the Ministry of Health psychiatric facilities. Provincial psychiatric hospitals are the responsibility of the Assistant Deputy Minister, Public and Mental Health via the Mental Health Division. However, almost 40 per cent of the province's psychiatric beds are located in general hospital psychiatric units and are funded through the general hospitals' global budgets. The general hospitals are the responsibility of the Associate Deputy Minister, Institutional Health Services through the Institutional Division, as are the two community hospitals, Royal Ottawa and Sudbury Algoma; Homewood Sanitorium; the Clarke Institute of Psychiatry; and the Addiction Research Foundation. Although the Assistant Deputy Minister, Public and Mental Health is responsible for policies and programs pertaining to the general hospital psychiatric units, he does not have control over their budgets. There is no "mental health budget" per se. Expenditures on mental health services come from a number of different funding sources within the Ministry of Health, and savings in one component - for example, provincial psychiatric hospitals or general hospital psychiatric units - are not necessarily transferable to other service components.

The general hospitals appear to be complying with the Minister's request not to reduce general hospital psychiatric unit budgets without his review. This, however, should be regarded as a short-term measure which provides an opportunity to review the implications of the current division of responsibilities.

Short of a major reorganization of Institutional Health Services, which is not recommended at this time, some means must be found to enhance the ability of the Assistant Deputy Minister, Public and Mental Health to ensure that the required programs are implemented in the general hospital psychiatric units which assist in achieving a balanced mental health care system, to monitor results and to carry out program changes as required. One possibility is for the Mental Health Division to purchase psychiatric services from the general hospitals. This approach may create difficulties in terms of determining the actual cost of the services to be purchased. Nonetheless, this approach is worth considering as one which does not appear to be unduly disruptive of existing reporting relationships and, at the same time, which meets the clear need to have effective responsibility for the planning, co-ordination and provision of mental health services under one Assistant Deputy Minister. A precedent exists in the funding by the Community Mental Health Services Program of treatment programs affiliated with general hospital psychiatric units.

Another interministry planning and co-ordination issue relates to the two statutory bodies in the field of mental health/addictions research: the Ontario Mental Health Foundation including the Clarke Institute of Psychiatry, and the Addiction Research Foundation. The Ministry does not have mechanisms in place to co-ordinate the work of these bodies with each other and with the Ministry's own programs. The recent establishment of the Health Research and Development Council of Ontario is intended to provide such a mechanism. It is not clear, however, that this will be sufficient because, with respect to these institutions, the mandate of the new Council is to "co-ordinate and assist". The allocation of responsibility for establishing and co-ordinating the research priorities and programs of these institutions within the broader context of provincial mental health priorities remains unresolved. This can be tackled through the instrument of Memoranda of Understanding as in the Government of Ontario Manual of Administration, and dealing with such matters as roles, responsibilities, accountability and co-ordinating procedures.

In general, therefore, there is a need for more effectively co-ordinated mental health service planning, resource allocation, program and research funding among the affected Ministry of Health divisions. An existing mechanism is the Area Health Services Committee, which would need strengthening to carry out these responsibilities. Alternatively, a co-ordinating committee could be established at the Assistant Deputy Minister level.

A basic component of effective planning and co-ordination is adequate and timely information. Information is needed for three related purposes: (1) to provide basic knowledge of the existing service system and its users as part of the Ministry of Health's responsibility and accountability to the public; (2) to monitor and evaluate the effects of on-going and new initiatives; and (3) to provide an early warning system for unintended and unexpected results.

The need for effective information systems in mental health has been widely recognized within and outside the Ministry for some time. There is a substantial amount of hospital-related data, particularly inpatient data, available but comparatively little regarding the activities of non-hospital mental health service providers; and what is available is not usually compatible with the hospital data.

The objectives, design, implementation and testing of any information system is a long and costly process with no guarantee that the desired results will be achieved. In addition, the design of an information system must balance potentially conflicting demands: available funds, maximum accuracy and comprehensiveness, maximum payoff for front-line staff, minimum time to record data and the collection of data which is manageable and capable of sustaining the detailed analysis required by different users to generate useful information and interpretation.

Effective information systems are built from the ground up. Front-line staff are the key information gatherers. Before they will make the effort to collect comprehensive and consistent data, they must be persuaded that the results will benefit them in their work. This implies an information system which is accessible to users in the affected agencies, which responds to on-going and ad hoc requests for information, and which provides timely data in a form most suitable to the level of management or provider requiring it. Such an information system must, therefore, consist of a common data base; one which pools and integrates the data from all relevant sources in a form accessible to a variety of users as a common resource. A corollary is the development of a staff resource for data analysis and interpretation, as well as for consultation with users.

Most existing information systems provide "event" data, for example, the number of hospital readmissions, rather than "person" data, for example, the number of times an individual has been readmitted. Person-based systems provide more useful information than event-based systems. However, the right of the patient or client to confidentiality must be respected and protected. Although the protection of these rights vis-a-vis the pragmatic requirements for useful information are not easily resolved, the emphasis in the design of information systems must be upon the right of the individual to privacy.

Several efforts in the development of such systems are already underway. An information system is in place in the Hamilton area which includes the inpatient and outpatient services of the local general hospital psychiatric units, a free standing psychiatric clinic and the Hamilton Psychiatric Hospital. The system is not yet connected with the community agencies in Hamilton, although it is reported that the data currently being collected by the agencies are compatible with those being collected by the larger information system. Woodstock General Hospital's Psychiatric Unit has an information system in place which includes the usual patient data as well as information on community referrals. An automated information system has recently been designed for Queen Street Mental Health Centre and will soon go to tender. It will eventually be extended to include the other nine provincial psychiatric hospitals.

RECOMMENDATIONS

- **STRENGTHEN MINISTRY OF HEALTH PROCEDURES FOR INTERNAL PLANNING AND CO-ORDINATION.**
- **MEMORANDA OF UNDERSTANDING BE ESTABLISHED BETWEEN THE MINISTRY OF HEALTH AND THE TWO STATUTORY FOUNDATIONS.**
- **ESTABLISH A COMPREHENSIVE MENTAL HEALTH INFORMATION SYSTEM.**

2.2.6 Interministry

The designation of the Ministry of Health as the lead ministry for adult mental health services has established the necessary basis upon which provincial government planning and co-ordination can be built. Currently, there are two major interministry committees in place which deal with mental health service questions:

> Interministry Committee on Housing and Support Services for Discharged Psychiatric Patients - designated by Cabinet minute and consisting of Assistant Deputy Ministers or their representatives from Health, Community and Social Services, Municipal Affairs and Housing and the Provincial Secretariat for Social Development;
>
> Interministry Committee on Children's Mental Health Services - consisting of representation from senior management of the Ministry of Health and the Ministry of Community and Social Services.

Interministry committees constitute potentially effective mechanisms for interministry planning and co-ordination. The need for interministry committees arises where individual ministries have overlapping responsibilities or where the boundaries of the ministries' responsibilities are not contiguous and gaps emerge. Services for two major target populations fall into these categories - children and adolescents, and persons requiring continuing support. So far as can be ascertained, the existing interministry committees are becoming increasingly effective in dealing with their individual mandates: co-ordination has improved, new initiatives have been undertaken and responsibilities are beginning to be sorted out.

The success of interministry committees depends in large measure upon both a commitment by the participants to deal with the outstanding issues in a co-operative manner, and the presence on the committee of senior management (i.e., assistant deputy minister level), able and willing to make policy decisions and to implement those decisions.

Until now, interministry committees have constituted internal government mechanisms for dealing with issues involving more than one ministry. The public must be made aware that the government is, in fact, attempting to find solutions to problems of fragmented responsibility through the use of these committees. As the work of the committees becomes better known, groups and individuals with interests which fall within the purview of these committees will seek access to them as the only government bodies capable of handling their concerns.

RECOMMENDATIONS

- **EXISTING INTERMINISTRY COMMITTEES CONTINUE AND NEW ONES BE FORMED AS THE NEED ARISES.**
- **THE MINISTRY OF HEALTH IN CONSULTATION WITH OTHER MINISTRIES PREPARE A DETAILED INVENTORY OF ALL THEIR MENTAL HEALTH-RELATED SERVICES AND PROGRAMS.**

3.0 CONTINUITY OF CARE

Continuity of care involves the provision of the appropriate type and level of treatment and support services to the individual who is mentally ill. The purpose is to assist the individual in maintaining himself or herself at the highest level of independent functioning possible and thereby to prevent or reduce unnecessary hospital admission or readmission.

The issue of continuity of care arises in two important areas: (1) treatment services and (2) rehabilitation and maintenance services.

3.1 TREATMENT: CRISIS SERVICES

Within the treatment component, resolving the issue of psychiatric crisis services should be a major priority. These services are unevenly distributed across the province and, where they are available, there is considerable variability in the nature and extent of crisis service actually provided. Two different systems of crisis services are in place: those located in provincial psychiatric hospitals, general hospital psychiatric units, and other psychiatric facilities; and those located in Ministry of Community and Social Services' Children's Mental Health Centres.

An adequate crisis service is characterized by: accessibility 24-hours a day, seven days a week; medical and psychiatric staff available at all times; a safely-keep unit or special observation room; and the capability to maintain the patient for a short period - up to 72 hours - during which time the patient's condition can be stabilized, a psychiatric, and if necessary a full medical, assessment carried out and a decision made regarding the most appropriate treatment and care program.

It is the policy of provincial psychiatric hospitals to have a psychiatrist or physician on call or, less commonly, on site 24-hours a day, seven days a week. They are, therefore, in a position to admit crisis patients whenever they appear. In defined cases, however, a patient will not be admitted but referred elsewhere. These cases include a patient whose physical condition is such that, in the opinion of the admitting physician, adequate medical care cannot be given; a patient who requires a medium secure setting and the hospital lacks one; and a patient who is intoxicated. Also, the lower age limit for admission is recognized to be 16 years except in "very special circumstances" where no other resources are available. All provincial psychiatric hospitals appear to be adhering to this policy and no changes to this policy are recommended until such time as their roles and the roles of other psychiatric facilities are defined as part of district and regional mental health plans.

Despite their Schedule 1 responsibilities, the situation with the general hospital psychiatric units is less satisfactory in relation to crisis services for both children and adults. Not all general hospital psychiatric units are providing 24-hour crisis services. The type of patient accepted for assessment is often dictated by the patient's behaviour, not only because of the lack of appropriately trained staff, but also because of the absence of safely-keep or special observation facilities. Consequently, in many cases the general hospital psychiatric unit will simply refer the patient to the nearest provincial psychiatric hospital or other psychiatric facility. Provincial psychiatric hospitals, however, are sometimes reluctant to admit crisis referrals from general hospital psychiatric units because they believe that the general hospital psychiatric unit should be able to provide the service and because provincial psychiatric hospitals do not always have the resources to provide the required medical intervention. General hospitals without a psychiatric unit are even more likely to refer the patient in crisis elsewhere. General practitioners can sometimes provide crisis service, but some general practitioners are not affiliated with a psychiatric facility.

With respect to crisis services specifically for children and adolescents, not all Children's Mental Health Centres are open on a 24-hour basis or during the weekends, essential characteristics of an adequate crisis service. Provincial psychiatric hospitals will take persons under 16 years of age in crisis on a short-term basis only when no other facility is available. One of the common complaints concerning general hospital psychiatric units is that they have highly variable practices concerning the admission of children to crisis services. These practices vary, not only from hospital to hospital, but also within each general hospital psychiatric unit, depending upon the staff in general emergency and in the psychiatric unit at the time the child arrives.

There are various models for crisis services which the Ministry of Health should review with respect to their usefulness in various districts of the province. In some crisis services, such as that provided by the Clarke Institute, the crisis team is multidisciplinary and includes psychiatrists, psychologists, social workers and nurses. In some cases, such as in Hamilton, one hospital in the area is designated as the hospital to provide psychiatric crisis services for both adults and children, and all other hospitals in the area refer such cases to it.

Another approach to delivering crisis services is that recommended in 1983 by the Durham Region District Health Council as part of its mental health plan. In order to extend crisis services out into the community, the Council has recommended a mobile crisis team be established. This approach tends, however, to be cumbersome and expensive.

In England there has been a similar program in various forms since the 1930s in which a designated mental health worker has the authority within a defined catchment area to visit persons in psychiatric crisis who are unwilling or unable to seek help. Where necessary in the opinion of the worker, he or she co-signs an order with a relative of the individual or with a doctor to have the patient admitted on a compulsory basis if the patient does not agree to be admitted. Alternatively, if inpatient crisis services are not required in the opinion of the mental health worker, the worker can arrange with medical, psychiatric or other mental health personnel for the provision of outpatient and other necessary services to the individual in crisis. This approach appears to work well.

These and other approaches are worthy of examination. The most appropriate form in which to provide crisis services in each of the health districts is a matter for consideration by the individual District Health Council in consultation with the Ministry of Health, taking into account the various costs and benefits.

RECOMMENDATIONS

- **EACH DISTRICT HEALTH COUNCIL BE RESPONSIBLE FOR ENSURING THAT ITS MENTAL HEALTH PLAN INCLUDES ADEQUATE PROVISION FOR CHILD AND ADULT CRISIS SERVICES ACROSS THE DISTRICT.**
- **THE MINISTRY OF HEALTH EMPHASIZE TO EACH GENERAL HOSPITAL WITH A PSYCHIATRIC UNIT THE IMPORTANCE OF ITS RESPONSIBILITIES UNDER SCHEDULE I AND TAKE APPROPRIATE ACTION TO ENABLE IT TO FULFILL THESE RESPONSIBILITIES.**
- **STAFF IN ALL GENERAL HOSPITAL EMERGENCY DEPARTMENTS BE TRAINED TO RECOGNIZE AND TO MANAGE THE PATIENT IN PSYCHIATRIC CRISIS ON A SHORT-TERM BASIS.**

3.2 TREATMENT: CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Mental health services for children and adolescents is one area which continues to experience discontinuity due to a lack of clarity between the two ministries, Community and Social Services and Health, regarding their respective responsibilities. In addition, there is a difference in philosophy over the role of treatment in service delivery: specifically, the emphasis that treatment should receive vis-a-vis care and support services. Fortunately, both approaches recognize that treatment is required in at least some cases. So long as the difference in philosophy can be expressed in terms of emphasis, the matter can be resolved in a pragmatic manner.

One segment of the target population has experienced considerable difficulty due to the division of responsibility between the two Ministries - persons between the ages of 16 and 19. This age group is at relatively high risk for the onset of major mental illnesses such as schizophrenia, and it is essential that such illnesses be identified and treated early and quickly. One of the difficulties is that some Children's Mental Health Centres will admit adolescents up to the age of 18 or 19 while others will take children only of a younger age. At the same time, some adult psychiatric services are reluctant to admit persons in this age group.(1)

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(1) The issue of crisis services for children and adolescents is discussed in the previous section.

The 19 Ministry of Health-funded general hospital outpatient clinics for children also suffer from a lack of consistency with respect to common services, and their roles in the community have lacked clear definition. Four of these general hospital psychiatric units have allocated beds for children in crisis, but the remainder of the general hospital psychiatric units have taken variable positions regarding the psychiatric assessment and treatment of children and adolescents.

Both Ministries - Community and Social Services and Health - recognize the need to improve the planning and co-ordination of children's and adolescent's services. In April 1983, the Interministry Committee on Children's Mental Health Services was reconstituted with a focussed agenda of issues. One of the issues being considered by the committee is the need to establish a joint planning and co-ordination mechanism at the local level.

It is essential that the two Ministries come to a clear and formal understanding about their respective responsibilities and that this understanding be communicated to the field level. There are several ways in which this could be accomplished:

(1) All Children's Mental Health Centres be transferred to the Ministry of Health;

(2) Those Children's Mental Health Centres emphasizing treatment be transferred to the Ministry of Health;

(3) The Ministry of Community and Social Services undertake to purchase all psychiatric services from the Ministry of Health and all treatment staff now working for the Ministry of Community and Social Services be transferred to the Health roster;

(4) Children's Mental Health Centres be established as autonomous community agencies with their own boards to be funded on a program basis by the Ministry of Health and the Ministry of Community and Social Services as appropriate.

My own preference is the last option.

Apart from the work of the interministry committees, there is a need for improved co-ordination between the two Ministries on a day-to-day basis. This can be accomplished through the offices of a special children's mental health consultant in the Mental Health Division and through staff in the respective field offices. These staff, however, will need clear directives regarding co-operation at the field level. It would be useful to formalize co-ordination between the two Ministries at the field level. One option is for each Area Office of the Ministry of Community and Social Services to establish a Joint Children's Mental Health Services Planning Committee. The functions of this committee would include planning and, particularly, co-ordination at the area level. Representation from the Ministry of Health might include appropriate members of the District Health Council mental health committees in the area.

RECOMMENDATIONS

- **THE MINISTRY OF HEALTH CLARIFY WITH THE MINISTRY OF COMMUNITY AND SOCIAL SERVICES THE ALLOCATION OF RESPONSIBILITIES FOR PROVIDING MENTAL HEALTH SERVICES TO CHILDREN AND ADOLESCENTS.**
- **JOINT CHILDREN'S MENTAL HEALTH SERVICES PLANNING COMMITTEES BE ESTABLISHED BY MINISTRY OF COMMUNITY AND SOCIAL SERVICES AREA OFFICES.**
- **THE MINISTRY OF HEALTH ESTABLISH THE POSITION OF SPECIAL CONSULTANT FOR CHILDREN'S MENTAL HEALTH SERVICES.**

3.3 REHABILITATION AND MAINTENANCE SERVICES

The purpose of rehabilitation services is to assist the psychiatrically disabled client to re-integrate into the community by increasing his or her ability to function independently (Anthony et al, 1978:365). The purpose of maintenance services is to maintain the individual at his or her fullest potential and/or to prevent the individual's condition or level of functioning from deteriorating (Cohen, 1982). The major difference between the two types of programs is not the programs themselves but the ends towards which they are directed: encouraging the individual to independent functioning or maintaining the individual, who cannot be fully independent, with the type and level of support necessary to prevent deterioration.

In the spectrum of rehabilitation and maintenance services, a place to live suitable to the needs of the individual is the first and fundamental component. Other important rehabilitation and maintenance services include educational and vocational rehabilitation services, social and recreational services and life skills training. In general, the goal is to normalize as far as possible the lives of those living in supportive housing settings and to provide programs for them during the day either in the home or outside.

The basic requirements for an effective system of continuing care consist of:

- Patient assessment and the development of an individual rehabilitation or maintenance plan;
- Discharge planning, including co-ordination of those services and accommodation to be provided to the patient upon discharge into the community;
- Case management for those persons with reduced competency attendant upon their mental illness;
- Monitoring of patient's rehabilitation and maintenance program;
- A capability for patients to move between various levels of care, treatment and support depending upon the degree of improvement or deterioration.
- Formal links for patient referral among agencies providing rehabilitation and maintenance services, and between these agencies and psychiatric and medical services.

A substantial proportion of persons who have been or are mentally ill require little or nothing in the way of support services. To the extent that they require on-going treatment, they are competent to ensure that their needs are met; and their requirements for rehabilitation services are often nil or of a short-term, transitional nature.

The primary target population requiring continuity of care is the chronically mentally ill person who does not require an inpatient setting for treatment, and who can live in the community if support services are available, but who suffers from a mental or emotional disorder that sharply limits the ability to interact with his or her environment in such a way as to sustain oneself adequately and/or relate competently to others (CMHA, 1982:18). Schizophrenia and the major affective psychoses are the typical diagnoses of this population. The size of this population has been estimated at between 0.35 and 1.0 per cent of the total population, or somewhere between 30,000 and 86,000 people in Ontario.

These candidates for rehabilitation and maintenance services fall into two major categories:

- Long-term psychiatric hospital patients who have been discharged to the community and other mentally ill persons who may be able to avoid hospitalization if the appropriate community rehabiliation and maintenance services are available.
- Psychiatric hospital patients who could be discharged if the appropriate support services were available.

These persons require essentially the same set of rehabilitation or maintenance services. The need is particularly acute for persons in the first category. Patients in the second category do not belong in a psychiatric hospital and include all those in the Low Psychiatric classifications (see Appendix A for classifications).

If the Low Psychiatric patient is also Low Physical, he or she can live at home in a supportive family setting or with chronic home care, or in a supportive housing program. Some form of psychiatric day care and case management may also be required.

If the Low Psychiatric patient is Medium Physical, it will be necessary to provide a more supportive setting encompassing continuing supervision of the physical condition. Existing facilities which could meet this need are Homes for the Aged and Nursing Homes, including those in the Homes for Special Care Program. Consideration also needs to be given to whether patients in the High Physical category are best located in the provincial psychiatric hospitals. Level of care surveys need to be carried out in each provincial psychiatric hospital to identify patients suitable for discharge, and the types and levels of treatment, care, rehabilitation and maintenance programs they will require upon discharge. The survey results can also be used to identify more precisely the requirements of those patients not suitable for discharge.

An essential characteristic of an effective system of continuing care is strong referral links between treatment services on the one hand and rehabilitation and maintenance services on the other, and among the various rehabilitation and maintenance services. Consequently, in some districts the emphasis will not be on establishing new services but on strengthening the links among those already available.

Looking ahead to the next decade, it appears that the existing distribution of rehabilitation and maintenance services will be inadequate to meet the needs of the chronically mentally ill, particularly that group moving into the psychogeriatric category. The separation of treatment from accommodation opens up possibilities for different forms of accommodation which can meet the physical requirements of the residents and provide for the delivery of treatment, rehabilitation and maintenance services to those accommodations - or bring the residents to these services.

The objective is to develop a continuum of rehabilitation and maintenance services to accommodate a range of clients from those who have high support needs to those who have minimal support needs.

RECOMMENDATIONS

- **FIRST PRIORITY FOR REHABILITATION AND MAINTENANCE SERVICES BE ACCORDED TO THOSE CHRONICALLY MENTALLY ILL PERSONS WITH REDUCED COPING ABILITY LIVING IN THE COMMUNITY; SECOND PRIORITY TO PSYCHIATRIC HOSPITAL PATIENTS WHO COULD BE DISCHARGED IF APPROPRIATE ALTERNATIVE SERVICES WERE AVAILABLE.**
- **THE MINISTRY OF HEALTH CARRY OUT A LEVEL OF CARE SURVEY IN EACH OF THE PROVINCIAL PSYCHIATRIC HOSPITALS.**

3.3.1 Accommodation: A Place to Live

The available stock of publicly-assisted accommodation for psychiatrically disabled individuals is not sufficient to meet the needs of those already in the community let alone those who could be discharged from psychiatric institutions if such accommodation were available. In order to redress this situation, a number of related measures should be examined: 1) revisions to existing eligibility criteria for publicly-assisted accommodation which exclude single persons under 65 years; 2) establishing specific units in Ontario Housing Corporation developments for psychiatrically disabled persons in locations where demand is sufficient; 3) the Ministry of Health to provide the necessary support programs to enable psychiatrically disabled persons to live in such accommodation; 4) the expansion of the Ontario Community Housing Assistance Program to include municipal non-profit corporations which can provide housing for this population.

The objectives and the operation of the Ministry of Health's Homes for Special Care and Approved Homes Programs also require review. Such a review should include the following matters: 1) co-ordination between the two programs; 2) existing admission criteria which exclude patients other than from provincial psychiatric hospitals; 3) the lack of programs for residents; and 4) existing selection criteria and training programs for home operators.

There is insufficient housing stock in the private sector, and those who are psychiatrically disabled often lack sufficient income to compete successfully in that market. If the Ministry of Health were to guarantee an agreed-upon number of residents, some private developers would be willing to provide the accommodation. This avenue should be explored. Several other related measures are proposed. A potential source of additional accommodation is through the "third-sector"; private non-profit and co-operative organizations. There are funds available to such organizations, for example from Canada Mortgage and Housing (Start-Up and Community Resource Organization Progam) to assist them in the provision of new housing stock. Some organizations, such as labour unions and co-operative societies, have on-going housing development programs with the assistance of third-sector funding. The Ministry of Health should review with such organizations the possibility of providing specific units in these housing programs for psychiatrically disabled persons in conjunction with appropriate Health-funded support services.

RECOMMENDATIONS

- **THE MINISTRY OF HEALTH REVIEW WITH THE MINISTRY OF MUNICIPAL AFFAIRS AND HOUSING WAYS TO IMPROVE THE ACCESSIBILITY OF PUBLICLY-ASSISTED HOUSING TO THOSE MENTALLY DISABLED PERSONS ABLE TO LIVE AT THIS LEVEL OF INDEPENDENCE.**
- **THE MINISTRY OF HEALTH REVIEW THE HOMES FOR SPECIAL CARE AND APPROVED HOMES PROGRAMS AND INTEGRATE THEM INTO A COMPREHENSIVE HOUSING PROGRAM.**
- **THE MINISTRY OF HEALTH ASSIST ORGANIZATIONS INTERESTED IN MENTAL HEALTH TO OBTAIN FUNDING TO PROVIDE ACCOMMODATION.**

3.3.2 Other Rehabilitation and Maintenance Services

In addition to a place to live, it is essential for this population that support services be in place. These include vocational/educational services, social/recreational services and life-skills training. Even where such programs exist, psychiatrically disabled persons sometimes lack sufficient discretionary income to pay the bus fare to get there. One of the difficulties is that a number of municipalities are interpreting social assistance eligibility criteria so that applications from the psychiatrically disabled are not being referred to the Regional Review Committees for consideration for Family Benefits Allowance.

There is a need to expand the number and improve the distribution of these vocational and other services across the province. In some parts of the province, where there is a dearth of mental health agencies and personnel to deliver the services, the Ministry of Health could purchase such services from other Ministries who have developed expertise in the field, for example, the Ministry of Community and Social Services.

Agencies involved in providing rehabilitation/maintenance services to mentally disabled persons should also consider expanding the scope of their programs to include support for the families of these persons; for example, counselling and respite programs.

Other Ministries provide important services in the field of rehabilitation and maintenance. The Ministry of Tourism and Recreation has a recreation consulting service for persons with mental and physical disabilities. This service includes funding to provincial and community organizations, resources, training and facilitation. About 10 municipal recreation departments have special needs co-ordinators who facilitate the provision of recreation and social programs for the physically and mentally disabled. Several of these special needs co-ordinator programs are funded on a sliding scale by the Ministry of Tourism and Recreation. This program has the potential for meeting a number of needs if it were expanded, particularly in areas underserviced by programs funded by Community Mental Health Services.

A range of work opportunities are required for persons in psychiatric rehabilitation programs, ranging from the sheltered workshop to mainstream work settings. The Ministry of Labour's Handicapped Employment Program, however, does not include the psychiatrically disabled.

RECOMMENDATIONS

- **REHABILITATION AND MAINTENANCE PROGRAMS BE EXPANDED.**
- **THE MINISTRY OF HEALTH CONSULT WITH THE MINISTRY OF TOURISM AND RECREATION REGARDING ITS SERVICES RELATED TO REHABILITATION AND MAINTENANCE.**
- **THE MINISTRY OF HEALTH ASK THE MINISTRY OF LABOUR TO EXPAND THE ELIGIBILITY CRITERIA OF ITS HANDICAPPED EMPLOYMENT PROGRAM TO INCLUDE THE PSYCHIATRICALLY DISABLED.**
- **THE MINISTRY OF HEALTH ENCOURAGE MUNICIPALITIES TO IMPROVE CRITERIA FOR THE REFERRAL OF SOCIAL ASSISTANCE APPLICATIONS FROM THE PSYCHIATRICALLY DISABLED TO THE REGIONAL REVIEW COMMITTEES FOR CONSIDERATION FOR FAMILY BENEFITS ALLOWANCE.**

4.0 HUMAN RESOURCES

4.1 INTRODUCTION

The inability of the public to obtain access to mental health services in any given area of the province often is the result of one or more factors:

- Uneven population distribution across the province;
- The tendency of professional resources to be clustered in the major urban centres;
- Language and cultural differences;
- The public's lack of knowledge of where to go for the most appropriate type of service to meet their needs.

The first three of these conditions are related to human resources, their distribution, education and training.

The goal is to give everyone in the province reasonable access to mental health services, no matter where they live. Of necessity, persons who live in the less populated areas, or who require more specialized services, may have to travel longer distances to obtain services than those who do not.

The key to improving access to mental health services across the province lies in making the best possible use of our available human resources. It is not necessary to alter radically the existing manpower structure or to create new "mental health disciplines". On the contrary, one of the purposes of the recommendations proposed in this section is to constrain the proliferation of additional categories of mental health professionals; rather the emphasis is on upgrading the skills of available resources and improving the allocation of these resources and the co-ordination among them.

To these ends, a number of different strategies are proposed. These are set out in more detail below, but can be summarized briefly. The requirements of the mental health patient or client need to be matched with the professional possessing the type and level of skills most appropriate to those requirements. This involves encouraging mental health professionals to refer patients or clients to other professionals when it is apparent that these other professionals have the more appropriate type and level of skills.

Similarly, it is necessary to bring some sense of consistency and coherence into the practice of therapy in the interests of clients/patients, employers of mental health workers and the practitioners themselves. A related strategy is to upgrade the training and skills of existing mental health practitioners so that the people already working in mental health can do more than they are doing, a particularly important requirement in underserviced areas. This requires an organizational framework within which the necessary staff training programs can be developed and delivered.

Although not easily accomplished, the basic objectives of the following recommendations are easily stated: (1) to make the most effective use of existing human resources in the mental health field; (2) to reduce geographic, language and cultural barriers to service.

4.2 HUMAN RESOURCE STRATEGIES

If we are to achieve the maximum benefits from our existing pool of human resources in the mental health field, we must strive to integrate these resources more closely and to establish more effective utilization and co-ordination among these resources.

Psychiatrists are the scarcest human resource in the mental health field, particularly outside the major urban centres. The question is how best to make use of their unique knowledge and skills. Funding and other mechanisms are necessary to encourage psychiatrists to place more emphasis upon consultation to, and the education and supervision of other mental health workers. There is persuasive evidence that, when psychiatrists adopt this consultative role with other professionals regarding their patients or clients, the number of these patients who require admission to psychiatric facilities is reduced (Cummings, 1979:36). One-to-one treatment will always remain an important component of the psychiatrist's workload; what is being recommended is a more effective proportioning of that workload between individual cases and consultation to other mental health practitioners. This can be accomplished in at least two ways: 1) funding mental health agencies to purchase psychiatric services at competitive fees for consultation, education, supervision and on-call services; or 2) altering OHIP fee schedules to enable psychiatrists to bill OHIP for consultation to community agencies.

It is also necessary to increase the number of psychiatrists both in underserviced areas and in the underserviced specialties - psychogeriatrics, children, forensic and addictions.

General practitioners are major providers of mental health services, and patients with mental disorders make up perhaps 20 per cent of their practice. As noted earlier, many general practitioners are not comfortable with patients with mental illness and emotional problems and some have received a limited amount of training to prepare them to deal with these kinds of problems. More recent graduates have had a greater emphasis placed on this important part of their training.

In addition, it appears that many persons treated by the general practitioner have less severe mental health problems. Given that a main thrust of this Discussion Paper is towards the best use of available resources, one has to ask whether the general practitioner is the best person to deal with some of these problems. Given the general practitioner's role as a major gatekeeper, his or her responsibilities should include efficient referral as well as treatment. One also has to ask about the more serious psychiatric cases which the general practitioner treats, the training which the general practitioner has received to deal with such cases, and the availability of specialized psychiatric backup.

Consequently, it is necessary to enhance the ability of the general practitioner (1) to treat successfully patients with mental illnesses and emotional disorders; and (2) to make use of non-medical treatment personnel or agencies for patients for whom this level of treatment is appropriate.

Sessional fees or their equivalent should also be available to allow general practitioners to bill for time spent on consultation regarding patients when the patient is not present.

There is a shortage of training programs in rehabilitation and maintenance services: five community colleges provide programs for "life skills coaches" and there is only one university level program for rehabilitation specialists. Given the importance of these services, training programs need to be expanded in scope and increased in number, particularly in underserviced areas. One must, however, be cognizant of the danger of over-training.

Volunteers already play an important role in mental health services and can play an even more important role. They represent a major source of additional human resources in the mental health field. There are volunteers already associated with established community mental health agencies and hospitals, and new volunteers are presenting themselves through the growing number of self-help groups. We need to make better use of our volunteers, to increase the number involved in mental health services and to encourage greater use of them in appropriate direct services such as counselling, home visiting and family support.

There are also large numbers of volunteers active in various community, recreation and sports and social services organizations. Given the prevalence of mental illness and emotional distress throughout the general population, it is reasonable to assume that a significant number of these volunteers will be willing to give some of their time to mental health activities. Access to this resource can be achieved through the Ministries already working with them, such as the Ministry of Tourism and Recreation, which has an extensive volunteer development program, and the Ministry of Community and Social Services. Given the size and importance of the volunteer sector, and the activities of other Ministries in this sector, the Ministry of Health will require some facilitating and co-ordinating capability, perhaps on a short-term basis pending evaluation.

RECOMMENDATIONS

- **THE MINISTRY OF HEALTH ENCOURAGE PSYCHIATRISTS TO ACT IN CONSULTATIVE, EDUCATIONAL, AND SUPERVISORY ROLES TO MENTAL HEALTH SERVICE PROVIDERS.**
- **THE MINISTRY OF HEALTH FUND THE DEVELOPMENT OF PROGRAMS THAT LINK FAMILY PRACTICE UNITS WITH PSYCHIATRIC FACILITIES.**
- **THE MINISTRY OF HEALTH DISCUSS WITH THE MINISTRY OF COLLEGES AND UNIVERSITIES THE EXPANSION OF TRAINING PROGRAMS FOR REHABILITATION WORKERS.**
- **A DIRECTORY FOR EACH HEALTH DISTRICT BE PREPARED OF BOTH FORMAL AND NON-FORMAL MENTAL HEALTH RESOURCES.**
- **THE MINISTRY OF HEALTH ESTABLISH THE POSITION OF CO-ORDINATOR OF VOLUNTEERS IN THE MENTAL HEALTH DIVISION.**

4.3 UNDERSERVICED POPULATIONS

Perhaps the most serious human resource problem is the uneven distribution of professional resources across the province, particularly in the less populated areas, and most particularly in the two northern regions. Another problem is the natural tendency of mental health professionals to locate in the five major health sciences teaching centres in the province.

Through its Underserviced Area Program, the Ministry of Health has had some success in attracting general practitioners to the north and other underserviced areas, and more recently in attracting psychiatrists to these areas. Although the program's mandate includes the recruitment of non-medical personnel, the per capita ratios of both social workers and psychologists in the north remain poor as Tables III-31 and III-32 indicate. The only professional personnel with mental health service capability reasonably evenly distributed across the province are the public health nurses.

The Ministry of Health and Ministry of Community and Social Services are already participating in jointly-funded programs in underserviced areas such as Chapleau, Lanark County and "North of Superior" to provide combined mental health services for children and adults. This model works well and should be expanded to other underserviced areas.

Generally, mental health professionals tend to practice close to the area where they have trained. Therefore, one promising strategy is to create opportunities in the north for persons already living in these areas to upgrade their skills. Full and part-time residency slots in northern affiliated teaching hospitals would attract residents in psychiatry to these less populated areas. The presence of these slots would also enable interested general practitioners in the underserviced areas to apply for residency in psychiatry without uprooting their family. Because the general practitioner is already established in the area, there is a greater likelihood that he or she will remain there once the training is completed. Training programs in northern institutions and affiliated teaching hospitals are of great importance. Not only will they give the northern population an opportunity to be trained without being uprooted, but also will provide training in a style of practice suitable to the north - recognizing that modelling is still the strongest influence on practice patterns.

Sudbury-Algoma Hospital and North Bay Psychiatric Hospitals have already been designated by the University of Western Ontario as affiliated psychiatric teaching hospitals. If full and/or part-time residency slots were established in these hospitals, cross-appointed psychiatric staff from the southern teaching hospital could supervise the residents' training. A pilot project could be established at these two affiliated teaching hospitals to examine the feasibility and value of such a strategy, including the use of Telehealth or other appropriate interactive communications technology for teaching and consultation among the affiliated hospitals and between them and the backup institution.

Some universities in the south are currently working to develop co-operative ventures with northern colleges and universities for the establishment of nursing programs in the north. This should continue. In designing these programs, consideration should be given to placing increased curriculum emphasis on the treatment of mental disorders and the style of practice suitable to these areas.

The preceding discussion addresses the general needs of underserviced areas. Specific attention needs to be paid to the issues of language and cultural accessibility.

In principle, mental health services in the French language should be available everywhere in the province where numbers warrant. Early in 1983 the Ministry of Health appointed a consultant for French language mental health services who is responsible for the recruitment of Francophone psychiatrists for service points in Northeastern and Eastern Ontario. This constitutes an important and necessary step towards improving Francophone services.

Native people face similar problems in accessing mental health services because of cultural differences. The native population in particular requires an approach to mental health services consonant with its cultural concepts and values. The matter is further complicated by jurisdictional issues: the federal government is responsible for health services for Treaty Indians and the provincial government is responsible for non-Treaty Indians. For native people in the north, the problem is worse because of the limited availability of mental health professionals. The District Health Council Program has, for some time, been responsible for all health care planning issues related to native people and one Area Planning Co-ordinator is designated as the Ministry of Health Senior Manager responsible for native health matters. The Ministry of Health recently retained the services of a consultant to advise on the development of mental health services targetted specifically to the native population.

Trent University has the only degree course in Native Studies in Canada. The university has also developed a curriculum for alcohol rehabilitation and adult mental health counselling as components of the course, although it has not yet been funded by the Ministry of Colleges and Universities. The federal government, through Indian and Northern Affairs, will provide maintenance allowances for students attending such courses. It is hoped that the Ministry of Colleges and Universities will approve the Trent alcohol rehabilitation and adult mental health counselling program quickly.

RECOMMENDATIONS

- **THE MINISTRY OF HEALTH AND THE MINISTRY OF COMMUNITY AND SOCIAL SERVICES INCREASE JOINTLY-FUNDED MENTAL HEALTH PROGRAMS IN UNDERSERVICED AREAS.**
- **HEALTH SCIENCES CENTRES BE ENCOURAGED TO DESIGNATE AFFILIATED TEACHING HOSPITALS IN UNDERSERVICED AREAS FOR PSYCHIATRIC TRAINING.**
- **THE MINISTRY OF HEALTH ASK THE MINISTRY OF COLLEGES AND UNIVERSITIES TO ESTABLISH NURSING PROGRAMS IN UNDERSERVICED AREA EDUCATIONAL INSTITUTIONS AND AFFILIATED TEACHING HOSPITALS.**
- **THE MINISTRY OF HEALTH ENCOURAGE THE DEVELOPMENT OF SERVICE MODELS FOR THE LOW DENSITY, REMOTE POPULATION AREAS OF THE PROVINCE.**
- **THE MINISTRY OF HEALTH ENCOURAGE THE DEVELOPMENT OF PSYCHIATRIC RESIDENCY SLOTS AND OTHER MENTAL HEALTH TRAINING PROGRAMS FOR FRANCOPHONES.**
- **THE MINISTRY OF HEALTH PURSUE THE DEVELOPMENT OF NATIVE MENTAL HEALTH PROFESSIONAL RESOURCES.**

4.4 HUMAN RESOURCE TRAINING AND DEVELOPMENT

The current state of affairs in the training of mental health professionals is problematic in that there is no accepted common body of knowledge. Not only are there considerable differences in the bodies of knowledge of the different professional groups, but there are also considerable differences within each profession, with the exception of psychiatry. For example, there are some 17 university and community college social work programs in the province, but it appears that there is no single core curriculum.

There is a need to ensure province-wide standards for those mental health professionals involved in providing therapy services. In many instances, the mental health worker's formal professional background is almost irrelevant to the skills and type of therapy being provided.

There is a need for a "Council of Therapists" or equivalent body. First consideration should be given to establishing the Council, or equivalent body, as an adjunct to the Ontario Mental Health Foundation which has the legislated mandate to provide the functions recommended for the Council. The responsibilities of the Council would be to establish a classification system for mental health workers who practice therapy, and standards or criteria for each classification of therapist.

The Council would seek representations from interested professionals who practice the various therapies, and review with universities, colleges and other teaching bodies these classifications, standards and criteria with respect to existing curricula and possible revisions to these curricula.

The criteria for meeting any given level of classification would take into account education, training, supervised experience and demonstrated skill. The classification system and attendant standards would be communicated to the mental health workers who practice therapy, to prospective employers of these workers, and to the public. Those mental health workers who wish could be identified as having met these standards. The Council would also consult with the various organizations and associations of mental health workers practicing therapy regarding the establishment of a common code of ethics for therapists.

Another important need is in the area of development, retraining and skills upgrading programs for mental health workers. Target groups for orientation, training and development programs include existing service providers, new recruits to the mental health field, psychiatric hospital administrators, hospital board members, members of mental health agency boards and District Health Councils, civil servants, police, volunteers and others involved in and with the mental health field.

An organization is required for the development and delivery of these programs, co-ordination of existing programs and teaching resources, curriculum development, liaison and similar activities. It should not be necessary to create a new "pile of bricks" for this organization; it can be housed in an existing facility. Teaching staff from various institutions and skilled professionals in the field can be seconded or work on short-term contracts. The training and development programs have to be accessible to people across the province, and this suggests the use of satellite, outreach and similar delivery modes using the resources available in teaching institutions.

It is proposed that the Ontario Mental Health Training, Development and Resource Centre be established. First consideration should be given to establishing the Centre as an adjunct to the Ontario Mental Health Foundation which already has the legislated mandate to provide the functions recommended for such a Centre. The responsibilities of the Centre would include the provision of orientation, training, retraining, skills upgrading and similar programs for those working in the mental health field.

The professions and other human resources in the mental health field would be consulted to develop standards for the required training and development programs. The Ministry of Health would formulate terms of reference with respect to the Centre's roles, responsibilities and accountability, and these would be incorporated into a Memorandum of Understanding.

The leadership of the Centre should, of course, be representative of recognized professions and skills in the mental health field. Existing training and development programs and resources in teaching and other institutions could be used where practical, and financial assistance should be provided to those persons wishing to attend Centre programs where travel and out-of-town residency are required for participation.

RECOMMENDATIONS

- **THE MINISTRY OF HEALTH ESTABLISH A "COUNCIL OF THERAPISTS" OR EQUIVALENT BODY.**
- **THE MINISTRY OF HEALTH ESTABLISH "THE ONTARIO MENTAL HEALTH TRAINING, DEVELOPMENT AND RESOURCE CENTRE" OR EQUIVALENT BODY.**

5.0 PROVINCIAL PSYCHIATRIC HOSPITALS

The detailed discussion on the provincial psychiatric hospitals indicated a wide range of issues which need to be considered. At the risk of oversimplification, these issues can be boiled down to two which are closely related:

> The relationship and accountability of the provincial psychiatric hospitals to the Ministry of Health.
>
> The roles and responsibilities of the provincial psychiatric hospitals in a decentralized mental health care system, and their relationship with the communities which they serve.

The other issues, such as quality of care, standards, public image, professional recruitment, flexibility to meet local needs, co-ordination with local services, can be subsumed under these two fundamental issues.

5.1 DIVESTMENT

The recent history of the divestment issue goes back at least to the mid 1960s when the then Minister of Health proposed the transfer to community agencies or boards of responsibility for all provincially-owned and operated hospitals. The Minister's proposal was consistent with the policy of placing responsibility for the delivery of services close to the point of need. The realistic expectation was that these agencies were better equipped than the Ministry, because of their position in the community, to identify and respond to local requirements quickly and efficiently. The responsibilities of the Ministry of Health were to ensure that provincial standards and priorities were met with respect to identified mental health needs and that adequate funding was in place for the designated agencies, including psychiatric facilities, to carry out their specified responsibilities.

It follows, therefore, that, unless there are overriding provincial interests, the Ministry of Health should divest itself of the provincial psychiatric hospitals. The major argument for the Ministry of Health to continue to own and operate the provincial psychiatric hospitals is the provincial interest in ensuring that the basic psychiatric services are in place and providing suitable standards of psychiatric treatment for the people of Ontario. This same argument, however, could be applied as well to the general hospitals with regard to medical treatment. Certainly, it is clear from the earlier discussion of the provincial psychiatric hospitals that there are considerable grounds for dissatisfaction with their performance to date. Some of the reasons for this dissatisfaction appear to arise out of the consequences of being owned and operated by the Ministry. Other reasons have to do with internal hospital and program management.

Given all the circumstances, it does not appear that there is an overriding provincial interest in the Ministry of Health retaining ownership and operation of the provincial psychiatric hospitals. The issue, therefore, is one of identifying the circumstances in and criteria under which divestment should occur. Implicit in such criteria must be the recognition that some provincial psychiatric hospitals will be ready for divestment before others. Unless and until these criteria are achieved by an individual provincial psychiatric hospital, divestment of that provincial psychiatric hospital would be premature. It is possible, therefore, that one or more provincial psychiatric hospitals will continue to be owned and operated by the Ministry for the foreseeable future.

There are two separate, but related, stages to deal with. The first concerns improvements to the existing situation in the psychiatric hospitals, prior to divestment or if divestment does not occur. The second concerns the criteria for divestment.

With respect to improvements to the existing situation, it is necessary to improve the skills and abilities of the provincial psychiatric hospitals to manage their affairs more effectively. Overall hospital management needs to be improved and, with respect to program management, improved direction and control are required vis-a-vis staffing and programming decisions.

Each provincial psychiatric hospital needs to develop a clearly articulated statement regarding its philosophy, management and patient care. In the area of management, for example, the hospitals should specify the roles and responsibilities of hospital management, including administrators and medical directors; budget, program and staffing procedures; and the procedures for monitoring and evaluating implementation. In the area of patient care, the hospitals should specify the types and levels of care to be provided, including inpatient, outpatient and day care; relationships with community services; the roles and activities of each patient care discipline; an operational definition of program management; and specifications for program monitoring and evaluation.

The definition of this statement for each provincial psychiatric hospital will need to be congruent with its roles within the various health districts it serves. The Ministry of Health will have to establish basic standards or guidelines regarding the management of the hospitals and patient care as a guide for the hospitals. In addition, the Ministry will need to review its own internal decision-making procedures so that the hospitals can develop the ability to respond quickly and efficiently to changing requirements as these arise. One of the common complaints of the hospitals is that they are not given sufficient opportunity to carry out their responsibilities effectively.

Orientation, training and development programs will be required for hospital board members, administrators, medical directors and others to upgrade the operations of the hospitals. These programs might be organized or provided by the proposed Ontario Mental Health Training, Development and Resource Centre. The Ministry should establish standards of training or competency in hospital management, administration and program management, and work with hospital personnel to assist them to meet these standards. Performance evaluation is an essential component of this process, and hospital and program managers should be required to perform to specified standards.

Staff training and development programs will also be needed for front-line hospital staff to better enable them to take on new positions as the roles of the provincial psychiatric hospitals in the community change. This will involve consultation with the Ontario Public Service Employees Union.

In order to attract highly qualified professional staff to the provincial psychiatric hospitals, particularly in the underserviced areas, a more flexible and competitive system of physician payments is needed. Options include replacing the salaried medical position with a contract arrangement, with an evaluation component built in; and sessional appointments for administration, consultation, education and backup services. Current sessional fee arrangements are not competitive, and psychiatrists working under this arrangement are not entitled to bill OHIP for those patients they treat in the hospital.

One possibility is for psychiatrists receiving sessional fees for non-billable services to bill OHIP for those patients whom they treat at the hospital; such billings would be to a stipulated maximum, and billings in excess of that maximum would be paid to the psychiatrist's teaching hospital, or other institution, to assist in research and education. The psychiatrist benefits by having access to these resources. This arrangement provides reasonable incentives for the psychiatrist and also establishes some check on potential misuse.

Criteria for divestment fall into several categories. The first concerns the clear definition of the roles and responsibilities of each provincial psychiatric hospital within the health region and districts it serves, including relationships with other mental health service providers. These will be defined in consultation with the District Health Councils on which the hospital should be represented.

The Community Advisory Board, or designated hospital board, of the individual hospital must demonstrate its competence to carry out its responsibilities. The same is true for the hospital administration. Criteria might include a defined management and organization structure; assignment to the Medical

Director of overall responsibility for patient treatment and care; demonstrated competence of management and administration to carry out the responsibilities assigned to them; a long-term hospital capital and operating financial plan, to be approved by the Ministry; and a long-term hospital program and services plan which includes inpatient, outpatient and community outreach components, and which meets the definition of roles and responsibilities for the hospital as defined in the District Health Councils' mental health plans.

The designated hospital board should also be able to demonstrate its ability to create a community base, including the establishment of a hospital volunteer organization with its own executive, defined areas of responsibility and an action program to carry out those responsibilities. Also, the hospitals should have a formal affiliation with a Health Sciences Centre or designated teaching hospital in order to ensure access to specialized psychiatric services, high standards of research and continuing professional and other staff education.

These criteria should be established by the Ministry and incorporated into a Memorandum of Understanding with each hospital.

Hospital staff will have to be involved in the planning and implementation of the divestment process. Front-line staff will likely take on new or expanded responsibilities. This will involve the proposed Ontario Mental Health Training, Development and Resource Centre, and the Ontario Public Service Employees Union should be consulted.

With the achievement of these, or similar criteria, the provincial psychiatric hospitals will develop into community-oriented agencies, strongly connected to teaching and research on the one hand and to local agencies and needs on the other, with clear roles and responsibilities, competent management and defined accountability to the Ministry of Health. The Ministry of Health would then have the necessary assurance that it can meet its basic responsibilities without owning and operating the particular provincial psychiatric hospital meeting the criteria.

RECOMMENDATIONS

- **EACH PROVINCIAL PSYCHIATRIC HOSPITAL DEVELOP A CLEARLY ARTICULATED STATEMENT REGARDING MANAGEMENT AND PATIENT CARE PHILOSOPHY.**
- **PROVINCIAL PSYCHIATRIC HOSPITAL COMMUNITY ADVISORY BOARDS, ADMINISTRATORS, MEDICAL AND PROGRAM DIRECTORS AND MANAGERS MEET STIPULATED STANDARDS OF PERFORMANCE.**
- **THE MINISTRY OF HEALTH ESTABLISH MORE COMPETITIVE PAYMENT SCHEDULES FOR PROVINCIAL PSYCHIATRIC HOSPITAL MEDICAL STAFF.**
- **THE MINISTRY OF HEALTH ESTABLISH CRITERIA FOR THE DIVESTMENT OF INDIVIDUAL PROVINCIAL PSYCHIATRIC HOSPITALS.**

5.2 PATIENT ADVOCATE PROGRAM

The Patient Advocate Program was established in mid-1983 to assist provincial psychiatric hospital patients to be fully aware of their rights and responsibilities and to take full advantage of the services and resources available to them. The terms of reference for the Patient Advocates tend to be general and leave room for considerable uncertainty over the scope and the specifics of their responsibilities.

In the first few months of the Program's operation, there have been a number of incidents which indicate some potential for the Patient Advocate to generate complaints rather than resolve them. It is important for the longer term that the scope and specifics of the Patient Advocate's responsibilities be defined in detail. Following are some of the more important issues which need to be resolved. Given the short period the program has been in operation, it may be premature to come to firm conclusions about all these issues.

(1) Is there an inherent conflict of interest in the Patient Advocate being employed by the Ministry of Health?

(2) Is the Patient Advocate entitled to access to the patient's files? If so, is the Patient Advocate free to reveal the contents of that file to the patient or to others, for example in court? If this is the case, what

protection is there for the physician who keeps confidential notes in his file regarding his assessment of the patient, an assessment which may change over time? Similarly, what protection is there for third parties who have provided the physician with confidential information about the patient - for example, with respect to incest or sexual abuse? If the confidentiality of the physician's files cannot be maintained, then where is confidential information to be held?

(3) The patient has a right both to treatment and to protection from abuses of his or her rights and person. Provincial psychiatric hospital staff also have a right to be protected from physical abuse by patients. Considerable attention is given to complaints about the abuse of patients' rights by provincial psychiatric hospital staff. There tends to be less attention given to the number of provincial psychiatric hospital front-line staff who require medical treatment because of assaultive behaviour by patients. To what extent is the Patient Advocate entitled to object to limitations being placed on the patient's ability to inflict such harm?

(4) If the patient declines treatment after consultation with the Patient Advocate, what is the position of the physician with respect to treatment? If the physician declines for professional reasons to alter that treatment, what options are available? Is the Patient Advocate entitled to object to the lack of treatment?

The Patient Advocate Program will be evaluated after its first two years of operation (mid-1985). Over the longer term, it is likely that some of the issues pertaining to the protection of patients rights against purported abuse will diminish as the provincial psychiatric hospitals develop closer ties with community agencies, become affiliated with Health Sciences Centres or affiliated teaching hospitals, and become more of a community resource - hence a more open, accessible and less threatening institution. One hopes that, as this process takes place, the need for the Patient Advocate will diminish.

In the meantime, the day-to-day issues raised above need to be tackled. One of the difficulties may be one of orientation or education. The Patient Advocates come from a variety of backgrounds and it is necessary to bring some consistency to their understanding of and approach to their work. It would be useful if all Patient Advocates were required to participate in an orientation program regarding mental illness, treatment philosophies and modes and forms of patient care.

RECOMMENDATIONS

- PATIENT ADVOCATES HAVE A DEMONSTRATED UNDERSTANDING OF MENTAL ILLNESS, TREATMENT AND PATIENT CARE.

- PATIENT ADVOCATES NOT HAVE ACCESS TO PATIENT FILES EXCEPT WITHIN CLEARLY DEFINED AND STRICTLY ENFORCED GUIDELINES WITH RESPECT TO CONFIDENTIALITY AND THE PROTECTION OF THIRD PARTIES.

- THE MINISTRY OF HEALTH SET OUT MORE PRECISE GUIDELINES CONCERNING THE RESPONSIBILITIES OF THE PATIENT ADVOCATE, THE POSITION OF THE PATIENT WHO DECLINES TREATMENT AND THE RIGHT OF PROVINCIAL PSYCHIATRIC HOSPITAL STAFF TO REASONABLE PROTECTION AGAINST BEHAVIOURALLY DISTURBED PATIENTS.

6.0 THE STATUTORY FOUNDATIONS AND MENTAL HEALTH SERVICES

6.1 INTRODUCTION

There are two statutory foundations: the Addiction Research Foundation and the Ontario Mental Health Foundation.

The basic issues appear to be that of accountability and priorities. There are no effective mechanisms in place for ensuring accountability of the foundations to the Ministry of Health or co-ordination between the foundations. The foundations were established as autonomous bodies with specified mandates and the question of accountability vis-a-vis autonomy is one which needs to be approached with respect for the autonomy side.

Recommendations are contained in this Discussion Paper concerning the need for the Ministry of Health to clarify its relationships with the statutory foundations so as to ensure a satisfactory level of accountability and co-ordination between the foundations and the Ministry. It is also recommended in this paper that the Ministry of Health establish Memoranda of Understanding with the foundations regarding their roles, responsibilities, reporting relationships, co-ordinating mechanisms and other matters directed towards achieving the necessary degree of accountability and co- ordination.

The following two recommendations deal with specifics of co-ordination between the two foundations.

RECOMMENDATIONS

- **THE MINISTRY OF HEALTH ENCOURAGE CROSS APPOINTMENTS AMONG THE BOARDS OF THE STATUTORY FOUNDATIONS AND OTHER ORGANIZATIONS.**
- **THE MINISTRY OF HEALTH ENCOURAGE THE FOUNDATIONS TO REVIEW OPPORTUNITIES FOR SHARING AND CO- ORDINATING RESOURCES.**

6.2 THE ADDICTION RESEARCH FOUNDATION

It has been recommended that essential services at the district level include addictions. This includes specialized assessment, referral, treatment and consultation services on both an inpatient and outpatient basis.

The broader issue is the co-ordination of the activities of the Addiction Research Foundation vis-a-vis other mental health resources at the local, district, regional and provincial levels. The Addiction Research Foundation has a wide range of skills and experience working with local agencies and it is important that these skills and experience, plus the specific activities of the foundation, be closely co-ordinated with those of other agencies. There are a number of possibilities, [illegible]ding:

- Representation on the District Health Councils or Regional Mental Health Committees;
- Participation in the proposed Ontario Mental Health Training, Development and Resource Centre;
- Secondment of foundation research staff and research activities to teaching institutions, particularly in underserviced areas, in order to strengthen programs in these areas.

RECOMMENDATION

- **CO-ORDINATION OF ADDICTION RESEARCH FOUNDATION RESOURCES WITH MENTAL HEALTH RESOURCES AT THE LOCAL, DISTRICT, REGIONAL AND PROVINCIAL LEVELS BE IMPROVED.**

6.3 THE ONTARIO MENTAL HEALTH FOUNDATION

The status of the Ontario Mental Health Foundation needs clarification. Its mandate includes research, education, delivery of mental health care services, public education and the Clarke Institute of Psychiatry. A number of recommendations have been proposed concerning various responsibilities which the Ontario Mental Health Foundation might undertake, including the proposed Council of Therapists and the proposed Ontario Mental Health Training, Development and Resource Centre. The functions proposed for the Council and the Centre are essential in order to bring some order into our human resources in mental health and to upgrade and retrain these resources. Within the scope of its existing mandate, the Ontario Mental Health Foundation can play a major role in linking mental health education, research and services at the provincial level. Possible activities include:

- Carrying out independent evaluations of mental health programs;
- Co-ordinating research proposals for funding from Ministry of Health sources;
- Working with teaching institutions to help strengthen them as regional research and educational centres;
- Assisting in the establishment of human resource training and development programs for use in teaching institutions and other agencies, providing such programs directly and on a contract or similar basis.

To carry out these responsibilities, and others associated with the proposed Council of Therapists and Ontario Mental Health Training, Development and Resource Centre, the foundation will need to be strengthened. Its funding will have to be increased consonant with its assigned responsibilities. The foundation will require a full-time chief executive officer, the position of Scientific Director should be made full-time, and additional support staff will be needed. The foundation's Medical Advisory Board, under the terms of the Ontario Mental Health Foundation Act, is limited to some health sciences centres and does not provide for representation from others involved in mental health care. In practice, the de facto membership of the board includes representation from all the Health Sciences Centres and non-medical professions. The Act should be revised to reflect this fact.

If the Ontario Mental Health Foundation is not to carry out these functions, some other body with a mandate similar to that of the Ontario Mental Health Foundation will have to be created in its place to carry them out.

With respect to the Clarke Institute, the original intention seems to have been to derive benefits from incorporating a university teaching hospital under the umbrella of the Ontario Mental Health Foundation. It does not appear that the Ontario Mental Health Foundation has exercised its mandated responsibilities vis-a-vis the Clarke or that there have been benefits as a result of its statutory relationship with the Clarke. Consequently, there seems to be no overriding reason why this statutory relationship should continue. If it does, however, the relationship between the foundation and the Clarke needs to be clarified.

The current activities of the Ontario Mental Health Foundation in the field of research are under review. A substantial proportion of the research funded by the Ontario Mental Health Foundation is basic or non-applied research although the Ministry of Health's recent research mandate and priorities are in the field of applied research. One of the difficulties is that federal funding for basic research in mental health is scarce and hard to come by.

RECOMMENDATIONS

- **THE ONTARIO MENTAL HEALTH FOUNDATION ACT BE REVISED AND THE STATUTORY RELATIONSHIP BETWEEN THE FOUNDATION AND THE CLARKE INSTITUTE OF PSYCHIATRY BE DISSOLVED.**
- **THE MINISTRY OF HEALTH CONTINUE TO REVIEW WITH THE ONTARIO MENTAL HEALTH FOUNDATION ITS RESEARCH FUNDING ALLOCATIONS.**
- **THE MINISTRY OF HEALTH ASSIST THE ONTARIO MENTAL HEALTH FOUNDATION TO REORGANIZE AND UPGRADE ITS RESOURCES.**

6.4 THE HEALTH RESEARCH AND DEVELOPMENT COUNCIL OF ONTARIO

The Health Research and Development Council of Ontario was created in 1983 to establish health research priorities and to evaluate research proposals submitted for Ministry of Health funding. Its role with respect to the statutory foundations is to assist them and to help them co-ordinate their research.

This co-ordination role is badly needed in the field of mental health research. It would be preferable, however, to have this co-ordinating function accomplished within the mental health research sector itself and carried out prior to submissions of mental health research proposals to the HRDCO. This would provide the HRDCO and the Ministry with the assurance that all mental health research proposals submitted to the HRDCO had already been reviewed and evaluated by a responsible body and deemed congruent with Ministry mental health priorities.

This co-ordinating body would identify high priority research in mental health, and encourage researchers to submit proposals in these high priority areas. In turn, the Ministry of Health would request the Council to refer back to the designated research co-ordinating body those mental health research proposals not first vetted by that body.

RECOMMENDATION

- **THE MINISTRY OF HEALTH ESTABLISH A CO-ORDINATING BODY FOR MENTAL HEALTH RESEARCH PROPOSALS.**

7.0 SPECIALIZED SERVICES

There are several areas of specialized mental health services which must receive attention:

Forensic
Developmentally Handicapped
Psychogeriatric

They are dealt with separately in the following sections.

7.1 FORENSIC

Three issues need to be dealt with. The first is that existing forensic psychiatric services are unevenly distributed across the province and their approach to service provision varies. The second issue arises out of the concern that a psychiatric facility, such as a provincial psychiatric hospital, serves both a non-forensic and a forensic population. This mixture adds to the stigmatization of the mentally ill as persons who require confinement.

The third issue arises out of the fragmentation of jurisdictional and administrative responsibility among the Ministries of Health, Attorney General and Correctional Services, with a resulting lack of clarity as to who is responsible for mental health services for mentally disordered offenders. In the allocation of responsibilities for the development of a comprehensive service network, the basic principle should be that each Ministry contributes what it does best: in the case of the Ministry of Health this means psychiatric assessment and treatment services.

There is also a need for a provincial centre of excellence in forensic psychiatric services. Such a centre could build upon the combined forensic expertise of the Clarke Institute of Psychiatry and METFORS. It is possible to move the Clarke's forensic service unit to METFORS at Queen Street Mental Health Centre, and use the combined resources of the Clarke's forensic unit and METFORS as a base upon which to build. This arrangement would have to be independent of the Queen Street Mental Health Centre.

The objectives of the recommendations are to establish a comprehensive network of forensic psychiatric services. Each provincial psychiatric hospital should have a special observation unit for its own behaviourally difficult, non-forensic patients. In addition, in each region there should be a medium secure unit for forensic patients providing psychiatric assessment and both inpatient and outpatient treatment. The outpatient service would be available for offenders who are not incarcerated. The Oak Ridge Division of Penetanguishene Mental Health Centre should continue to provide the maximum secure forensic services for the province. The physical design of the facility may require improvement. Forensic patients currently at Oak Ridge who do not require a maximum secure setting should be transferred to a regional medium secure unit closer to their home, thereby making more beds available at Oak Ridge.

To ensure integrated service delivery, the medium secure units would have a regional advisory committee consisting of representatives from the responsible ministries: Health, Attorney General, Correctional Services and Solicitor General. The advisory committee should also include representation from related addiction services: Addiction Research Foundation, the Detoxification Centres and the Halfway House Program of the Ministry of Community and Social Services.

The Ministries of the Attorney General and Correctional Services would be responsible for the design and operation of the medium and maximum secure units, and would purchase psychiatric services from the Ministry of Health.

An overall provincial advisory committee is required for planning and co-ordination of service delivery, research and education. Representation on the committee should be at the Assistant Deputy Minister level from the Ministries of Health, Attorney General, Correctional Services, Solicitor General and the Policy Secretariat for Justice. An alternative mechanism is that used in British Columbia where a Forensic Psychiatric Services

Commission was established with administrative and financial control over all provincial forensic psychiatric services. There can, however, be several difficulties with this approach: one is that it involves the establishment of a new statutory body with a considerable degree of autonomy and with the likely accompanying problems of accountability, financial controls and co- ordination with government ministries. The preferred approach is the senior-level committee which acts in an advisory capacity with respect to planning and co-ordination.

RECOMMENDATIONS

- **A COMPREHENSIVE NETWORK OF FORENSIC PSYCHIATRIC SERVICES, INCLUDING ASSESSMENT, TREATMENT, TEACHING AND RESEARCH, BE ESTABLISHED.**
- **A PROVINCIAL ADVISORY COMMITTEE ON FORENSIC PSYCHIATRIC SERVICES BE ESTABLISHED.**
- **A PROVINCIAL CENTRE OF EXCELLENCE IN FORENSIC PSYCHIATRIC SERVICES BE ESTABLISHED.**

7.2 THE DEVELOPMENTALLY HANDICAPPED

The psychiatric problems of the developmentally handicapped have come into clearer focus in the past two decades or so as the pattern of care has altered and deinstitutionalization increased. A recent survey indicated that approximately 17 per cent of the patient population at Penetanguishene Mental Health Centre are developmentally handicapped; the proportion is growing steadily because of the difficulty in finding community placements for those developmentally handicapped whose mental illness has stabilized and who are ready for discharge. In the Ministry of Community and Social Services' mental retardation facilities about 15 per cent of the residents display a high degree of disturbed behaviour (Ontario Ministry of Community and Social Services, 1980b).

There are several issues which need to be resolved. Generally, there are inadequate assessment and treatment services for the disturbed developmentally handicapped in the province, and there is an uneven distribution of beds for them across the province. Currently, there are five provincial psychiatric hospitals providing 142 beds in specialized units for disturbed mentally retarded persons; none of these are in the north.

There are three main groups of developmentally handicapped for whom mental health services are required:

(1) The aggressive, seriously disturbed who require a secure, long- term setting for treatment and care;

(2) The less disturbed who require psychiatric intervention on a short-term inpatient treatment basis in a provincial psychiatric hospital or general hospital psychiatric unit until they are stabilized;

(3) Those in the community in residential programs - agencies providing these programs require psychiatric consultation as backup to their services and financial arrangements are needed through which psychiatrists can provide consultation to these agencies.

A second issue is the divided responsibility for services between Health and Community and Social Services, and the lack of defined objectives and of co-ordinated mental health services for the disturbed developmentally handicapped. A third issue is the scarcity of mental health professionals trained to work with the developmentally handicapped.

The objectives of the recommendations are to expand psychiatric services to the developmentally handicapped and to improve co-ordination among the various services of the Ministries of Health and of Community and Social Services. The Ministry of Health can improve co-ordination by designating a special consultant to advise it and to liaise with the Ministry of Community and Social Services.

The expansion of services requires a special unit, preferably a provincial psychiatric hospital because of its existing facilities, in each health region, and a general hospital psychiatric unit in each health district, designated for the developmentally handicapped. The provincial psychiatric hospitals would provide services primarily for the aggressive and seriously disturbed who require a secure setting for extended treatment and care. The general hospital psychiatric units would provide services for those who require short-term psychiatric inpatient treatment; and also provide consultation to local agencies and mental health professionals to help them help the developmentally handicapped to live in the community.

The supply of professionals in this field can be increased in two ways: establishing post-graduate residency slots designated specifically for training in the field of the developmentally handicapped; and staff training and upgrading programs. The training programs can be designed and sponsored or delivered through the proposed Ontario Mental Health Training, Development and Resource Centre.

RECOMMENDATIONS

- **THE MINISTRY OF HEALTH APPOINT A SPECIAL CONSULTANT IN PSYCHIATRIC SERVICES FOR DEVELOPMENTALLY HANDICAPPED PERSONS.**
- **THE MINISTRY OF HEALTH EXPAND SERVICES TO THE DEVELOPMENTALLY HANDICAPPED.**
- **THE MINISTRY OF HEALTH INCREASE THE SUPPLY OF MENTAL HEATH PROFESSIONALS QUALIFIED TO WORK WITH THE DEVELOPMENTALLY HANDICAPPED.**
- **THE MINISTRY OF HEALTH IDENTIFY A HEALTH SCIENCES CENTRE TO BECOME A PROVINCIAL CENTRE OF EXCELLENCE FOR THE DEVELOPMENTALLY HANDICAPPED.**

7.3 PSYCHOGERIATRIC

With the greying of the population, the demand for long-term psychogeriatric care will increase steadily and substantially over the coming decades. The problem will become particularly acute as the numbers of the "old-old" (85 years and over) increase, given the incidence of Alzheimer's disease with this population, as well as the gradual clustering of chronicity (e.g., Arie, 1978; Fahey, 1983). Because women tend to live longer than men, most of the old-old are women living alone on a small income in circumstances which increases the potential for mental health problems.

The elderly suffer from the full range of mental disorders; depression may be the most common, although it is difficult to diagnose because it often masquerades in many physical, emotional and behavioural guises. Estimates of the prevalence of mental illness among the elderly vary, some estimates ranging as high as 30 per cent, with about half of these illnesses of a disabling nature.

The field of psychogeriatrics is not one which has attracted an adequate number of psychiatrists or other mental health professionals, nor are there an adequate number of services available. There also appears to be some reluctance among mental health professionals and institutions to deal with psychogeriatric cases. Given the current demand, and the projected increase in demand for psychogeriatric services over the next decades, these are inadequacies which need to be dealt with. More psychiatric residency slots and training programs are required, and increased emphasis needs to be placed upon psychogeriatrics in the curricula for mental health professionals.

Elderly people requiring psychiatric services almost always require medical services as well. Many psychogeriatrics have fluctuating physical and mental illnesses for which they require a flexible range of services enabling them to move into acute medical or psychiatric care on short notice and then, as their condition stabilizes, back into a less intensive supportive or treatment setting. Because of the geriatric's often frail or vulnerable physical condition, these services should be provided in one location, or reasonably close to each other or delivered to the individual's residence. Consequently, there are sound reasons for combining, co-ordinating or linking psychogeriatric services with medical services and with accommodation.

Currently, psychogeriatrics have a limited range of accommodation options available to them: hospital settings, homes for the aged, nursing homes and private residences. Most of the publicly-funded accommodation settings have few or no vacant beds. Outpatient psychiatric assessment and treatment services are even less available, as are support services. Those services which are available are poorly co-ordinated.

The intention is to strengthen and co-ordinate a network of assessment, treatment, medical, accommodation and other services for psychogeriatrics. Individuals would be in an inpatient setting only when necessary in order to deal with a specific psychiatric or medical condition, and not as a substitute for non-inpatient services. Close co-ordination is required between the Ministries of Health and Community and Social Services. The Ministry of Health needs to designate a special consultant in psychogeriatrics to advise the Ministry and liaise with the Ministry of Community and Social Services.

The District Health Councils should encourage local agencies to develop multidisciplinary, multiservice psychogeriatric programs which combine psychiatric assessment and treatment, medical services and maintenance programs, including accommodation. Because general hospital psychiatric units already possess the basic psychiatric and medical services required by psychogeriatrics, they can provide the backbone of these services in each health district, including consultation to other community agencies involved in providing services to psychogeriatrics. At least one general hospital psychiatric unit in each health district should be designated to provide the full range of these services.

There is an excellent opportunity to experiment on a pilot project basis, incorporating accommodation and associated support programs as part of the psychogeriatric service provided by a general hospital psychiatric unit to its health district. There are several models from which to draw. This project will require close co-ordination of services with the full support of the hospital, the District Health Council, the affected local agencies and the Ministry of Municipal Affairs and Housing.

RECOMMENDATIONS

- **THE MINISTRY OF HEALTH ESTABLISH THE POSITION OF SPECIAL CONSULTANT FOR PSYCHOGERIATRIC SERVICES.**
- **THE MINISTRY OF HEALTH REQUEST THE DISTRICT HEALTH COUNCILS TO ENCOURAGE PROPOSALS FOR PSYCHOGERIATRIC PROGRAMS.**
- **THE MINISTRY OF HEALTH IDENTIFY A HEALTH SCIENCES CENTRE TO BECOME A PROVINCIAL CENTRE OF EXCELLENCE IN THE FIELD OF PSYCHOGERIATRICS.**
- **THE MINISTRY OF HEALTH DESIGNATE PSYCHIATRIC RESIDENCY SLOTS AND ENCOURAGE TRAINING PROGRAMS IN PSYCHOGERIATRICS.**

- **THE MINISTRY OF HEALTH ASK THE MINISTRY OF COLLEGES AND UNIVERSITIES TO INCREASE THE EMPHASIS UPON PSYCHOGERIATRICS IN THE CURRICULA OF MENTAL HEALTH PROFESSIONS.**

- **ONE GENERAL HOSPITAL PSYCHIATRIC UNIT BE DESIGNATED WITHIN EACH HEALTH DISTRICT TO PROVIDE FULL PSYCHOGERIATRIC SERVICES.**

- **THE MINISTRY OF HEALTH ESTABLISH A PILOT PROJECT INCORPORATING PSYCHOGERIATRIC TREATMENT, ACCOMMODATION AND SUPPORT SERVICES CO-ORDINATED BY A GENERAL HOSPITAL.**

8.0 PREVENTION

Previous recommendations concerning treatment, continuity of care and rehabilitation and maintenance services fall into the general category of secondary and tertiary prevention.

The following discussion concentrates on primary prevention. Primary prevention is directed towards reducing the incidence in the population of new cases of a disease or illness. Programs typically adopt one of two strategies: modifying the environment so as to reduce the stresses or conditions which lead to the disorder or dysfunction; or improving the ability of the individual to cope with the environmental conditions. The latter strategy appears to be the more feasible in the context of mental health.

Primary prevention programs in mental health have proven to be difficult to mount and their effectiveness is hard to gauge. A well-designed primary prevention program should be grounded in a knowledge base from which one can reasonably infer that specified results will follow from specified actions. There are not a significant number of models of effective primary prevention programs in mental health which meet this criterion.

Nonetheless, effective primary prevention programs in mental health are essential if we are to place some reasonable limits on the increasing demands for mental health services which are projected for the coming years. In the current economic situation, first priority should be given to building on existing models, programs, experience and resources which have already demonstrated significant results.

The workplace population is proposed as a high priority because of the number of mental health prevention programs already in place: they have produced satisfactory evidence of measurable benefit; the number of such programs is increasing, and they are gaining increasing support from employers. Considering that most of the adult population in Ontario is employed, the workplace seems a logical place for the Ministry of Health to devote some of its energies in the area of mental health primary prevention.

Programs which have demonstrated an ability to improve mental health and to reduce the incidence of mental illness in the workplace include: physical fitness and recreation programs, employee assistance programs and health and lifestyle promotion programs. Ministries involved in these programs include Tourism and Recreation, Labour and Government Services. A number of agencies are also involved in this field: the Canadian Mental Health Association, the Addiction Research Foundation, Metro Toronto Family Service Association, Participaction and the newly-formed Employee Assistance Program Association. In short, there are considerable resources and experience in primary prevention in mental health from which the Ministry of Health can benefit. The Ministry of Health will need a special co-ordinator in primary prevention to advise it and to liaise with other Ministries, organizations and private companies involved in such programs.

The second group which deserves high priority consists of children and adolescents, particularly children and adolescents in high risk groups, such as those in broken homes and other stressful environments and young children with an organic disorder that may predispose them to mental illness. It is particularly important that these groups be identified and prevention measures instituted.

Unfortunately, while there is considerable literature on the subject of the need for primary prevention programs for children and adolescents (Ontario Ministry of Community and Social Services, 1979), there is less on appropriate primary prevention programs. This area requires more study in order to design effective programs. One modest option is the use of unstructured play areas for young children which provide opportunities to develop problem-solving skills and thereby enhance ability to cope. Such playgrounds are common in England and Euorpe, and there are increasing numbers of them in North America. Also, the Ministry of Tourism and Recreation has funded research into the effects on children of long-term participation in sports programs.

This and similar research will have to be reviewed in consultation with Tourism and Recreation, Community and Social Services and others as a necessary step in the design and development of primary prevention programs which build upon demonstrated experience.

Residents in at-risk communities, such as those with high levels of unemployment, are themselves at risk with respect to their mental health. Studies show a clear relationship between unemployment and psychiatric first admissions in the psychotic category, and a measurable relationship between unemployment and mortality, suicide, family breakdown, alcoholism, violent crime, delinquency and prison admissions (Sullivan and Finlay, 1983:4). Given the established relationship between recreation and physical fitness programs and mental health (Berger, 1983; Pearl and Berger, 1983), it is reasonable to assume that similar results can be obtained from the implementation of such programs, appropriately designed and implemented, in these communities.

One of the mainstays of at-risk communities is the network of community organizations and agencies which provide a variety of facilitation, support, counselling and other services to the community. Such organizations provide the backbone of community efforts at self-help. The Ministry of Health does not have a large field staff dedicated to facilitating the development and operation of such community organizations. The Ministry of Community and Social Services has experience in this area, and Ministry of Tourism and Recreation, Recreation Division, has a province-wide field staff dedicated to community facilitation, to providing startup funds and to assisting community organizations to obtain Wintario and other public funding.

The field of primary prevention in mental health is wide ranging. The first steps, necessarily, are to clarify what everyone else is doing and to review possible roles which the Ministry of Health might play. In this process an inventory of programs directly and indirectly related to primary prevention in mental health should be prepared as a reference tool and basis for policy and program review by the Ministry.

RECOMMENDATIONS

- THREE TARGET POPULATIONS RECEIVE HIGH PRIORITY:
  1. Employees in the workplace;
  2. Residents of at-risk communities;
  3. Children and adolescents in at-risk categories.
- THE MINISTRY OF HEALTH CONSULT WITH OTHER MINISTRIES AND PRIVATE SECTOR ORGANIZATIONS REGARDING THE DEVELOPMENT OF MENTAL HEALTH PRIMARY PREVENTION PROGRAMS.
- THE MINISTRY OF HEALTH APPOINT A SPECIAL CONSULTANT IN PRIMARY PREVENTION IN MENTAL HEALTH TO LIAISE WITH OTHER MINISTRIES, ORGANIZATIONS AND COMPANIES.

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APPENDIX A

CHART AIII-1

SERVICE AREAS

Ministry	Adult Mental Health	Child/Adol. Mental Health	Forensic	Accommodation	Income Maintenance	Vocational/Ed. Rehabilitation	Rehabilitat'n (life skills/ social & rec.)	Teaching/ Training	Research
PROVINCIAL									
Health	Provincial Psychiatric Hospitals; Community Mental Health Services; Home Care Program; General Hospital Psychiatric Units; General Hospitals; official local health agencies.	19 Children's M.H. Clinics (outpatient) in General Hospitals & 13 services jointly funded with MCSS (4 of these are child & adolescent units in P.P.Hs).	Through open forensic beds & medium secure forensic units in P.P.Hs; maximum secure division of Penetanguishene M.H.C.; Clarke Institute of Psychiatry; Royal Ottawa Hosp	Some Community Mental Health Services programs; Homes for Special Care Program.		Through P.P.H. vocational counselling & industrial workshops; some Community Mental Health Services programs.	Through P.P.Hs; some Community Mental Health Services programs.	Continuing education in P.P.Hs.	O.M.H.F.; A.R.F.; Policy Analysis and Research Branch.
Community and Social Services		73 Children's Mental Health Centres; 4 services jointly funded with HEALTH; Family Court Clinics.			Family Benefits Allowance; General Welfare Assistance.	Workshop Program; Vocational Rehabilitation Services.	Vocational Rehabilitation Services.		
Municipal Affairs and Housing				Rent supplements, among others, physically & handicapped persons; funds for developing rent-geared-to-income housing; municipal non-profit housing; private non-profit & co-op housing.					

Ministry	Adult Mental Health	Child/Adol. Mental Health	Forensic	Accommodation	Income Maintenance	Vocational/Ed. Rehabilitation	Rehabilitat'n (life skills/ social & rec.)	Teaching/ Training	Research
Provincial Secretariat for Social Development				Interministerial Committee on Housing for Ex-psychiatric Patients.					
Colleges and Universities								Community College courses; 5 Health Sciences Centres.	
Civil Service Commission						Employment by government of handicapped (incl. psychiatrically handicapped).			
Education		Early identification program in elementary schools education in government approved/licensed C.M.H. Centres; school guidance programs.							
Labour						Handicapped Employment Program; Workers' Compensation Board.			
Tourism and Recreation									

Ministry	Adult Mental Health	Child/Adol. Mental Health	Forensic	Accommodation	Income Maintenance	Vocational/Ed. Rehabilitation	Rehabilitat'n (life skills/ social & rec.)	Teaching/ Training	Research
Attorney General			Metfors; Provincial Courts (Family Division).						
Correctional Services			Funds full-time psychiatric consultants to correctional institutions.						
LOCAL									
Municipal/ Regional Government	Official local health agencies; social service departments.			General Welfare Assistance for housing on an emergency basis; hostels; licensing for group homes; zoning bylaws; municipal non-profit housing projects.	Administer G.W. Assistance through social service departments.				
FEDERAL									
Employment and Immigration						Employment Counselling Programs			
Health and Welfare	Native health; veterans; grants to community groups.								Extra-mural research grants; publications; conferences; task forces; in-house research & consultation.

Chart AIII-2

DESCRIPTION OF PATIENT CLASSIFICATION LEVELS

PHYSICAL AXIS

High

- Require close observation
- Acute symptoms
- May need continuous support of ADL
- Special treatments and/or meds (evaluation, special equipment, I.V.'s, etc)
- Limited patient mobility
- May have limited verbal communication

Medium

- Stabilized symptoms
- Intermittent assistance with ADL
- Requires education in treatments and medications
- Self-mobile
- Moderate use of communication skills

Low

- Physically self-reliant
- Requires occasional monitoring of symptoms
- Requires monitoring of ADL at appropriate times
- Routine treatments and medications
- Ambulatory
- Communicative

PSYCHIATRIC AXIS

"Admissions" Category*

- Patient currently undergoing admissions assessment procedures
- Treatment plan not yet finalized by staff
- Data gathering intensity high
- Admitted less than 15 days

High

- Requires intensive observation, supervision, and/or treatment
- Presence of florid psychiatric symptoms
- Dangerous to self, others, and/or property

Medium

- Not a hazard to self or others
- Lack of social competence or functional capacity
- Requires co-ordination of activites and a consistent structured program

Low

- Does not require inpatient hospitalization in a psychiatric setting
- Requires stability maintenance processes
- Ready to be referred to community-based settings (nursing homes, patient's family, foster homes, etc.)

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* "Admissions" is included on the psychiatric axis since most of the unknowns concern the psychiatric rather than the physical component of patient needs.

Source: Medicus Canada, 1983.

APPENDIX B

ALTERNATIVE MODELS(1)

1. The Balanced Service System - Georgia Mental Health Institute(2)

The Balanced Service System attempts to integrate the concepts of the patient population being served, the types of services offered and the environment where these services are offered.

The Balanced Service System (B.S.S.) is divided into five areas of functioning; service, administration, citizen participation, research and evaluation and staff development. For purposes of this brief review only the service component will be dealt with.

The B.S.S. presents a priority system on who is increasingly being served or targetted populations who should be served.

First Priority:	Individuals at high risk for psychiatric hospitalization and/or institutional care.

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(1) This description of four different approaches to the provision of a comprehensive network of mental health services is an excerpt from Deborah B. Cohen's paper entitled Mental Health Service Provision in Ontario: A Conceptual and Definitional Framework (1982). It is reproduced with her kind permission.

(2) This review paraphrases sections from: Charles Melville, ed. The Balanced Service System: An Approach to the Delivery of Mental Health Services, Georgia Mental Health Institute, February 1977.

Second Priority: Individuals with significant dysfunction in one or more life areas who might otherwise "suffer in silence" or who might come for help when in a crisis.

Third Priority: Persons with mild or self-limited emotional problems who might present with psychiatric symptoms during periods of stress or crisis.

Fourth Priority: "Normal" individuals (without identifiable mental or emotional disability) seeking personal growth and/or self-enrichment. Resources permitting, attempts will be made to identify and contribute to the development of resources outside this program which can meet many of the needs of this segment of the population. Resources permitting, the Mental Health Services may provide a limited number of growth promoting learning experiences designed to prevent common dysfunctions in special target groups, e.g. marriage enrichment, family life, needs of the aged, communication, etc., provided that such experiences are self-supporting through fees or special grants.

The Balanced Service System attempts to serve individuals in the four targetted populations listed above, with three relatively specific types of services: crisis stabilization, sustenance and growth services. In general, the B.S.S. is based on the philosophy that services should be provided in the most natural, least restrictive environment possible (dependent on the degree of disability of the consumer, as well as his/her current functional abilities) and that there should be a case co-ordinated set of procedures with the general goal of stabilization, sustenance or growth. As such, the B.S.S. proposes that services should be provided in three different environmental settings; the natural, supportive or protective environments.

The natural environment is the environment where individuals normally function and includes those persons who provide support in times of crisis. Only when the folk-support system is not able to provide service is there utilization of the professional system. It is seen as preferable for the mental health worker to go to the natural environment to provide the professional service. If services cannot be offered in the natural environment, it is preferable to offer them in the less restrictive supportive environment of the centre or agency than in the protective environment provided by hospitalization.

The Balanced Service System recognizes that there is a wide range of services that can be offered both on the consumer's "turf" in the natural environment and in the supportive or protective environment on the professional's "turf". A balanced system should be composed of a variety of co-equal service components each of which has a relatively exclusive function. The B.S.S. identifies eight such functions.

1. **IDENTIFICATION** activities are aimed at determining who needs services.

2. **CASE MANAGEMENT** coordinates activities in the other service areas. It facilitates client movement through the system so that at any given time needs are matched by the services received. The five case management activities are: assessment, planning, linking monitoring and advocacy.

   Case Management assures appropriate utilization of:

   3. **CRISIS STABILIZATION** serves persons with severe, usually sudden, decrease in their normal level of functioning. The goal is to restore, as quickly as possible, a level of functioning sufficient to allow them to return home or to receive services in a less restrictive setting.

   4. **SUSTENANCE** programs are for people who need help to remain at their current level of functioning. Without assistance, they would "backslide". The degree and duration of help given will vary with the individual's needs. However, the goal is to give the minimum help required and to encourage people to care for themselves as much as possible.

   5. **GROWTH** services are for people who want to improve their personal satisfaction, their interpersonal skills or their general level of functioning. In contrast to stabilization (which helps regain lost skills) or sustenance (which protects skills from being lost), growth programs help develop new skills.

   6. **ANCILLARY** services complement the other seven services, e.g., dietary services, pharmacy.

   7. **GENERAL HEALTH** promotes or restores physical health. These services are usually provided in combination with others, e.g. stabilization.

8. **PREVENTION** refers to activities aimed at substantially reducing the probability of the occurrence of mental disabilities resulting from social, emotional, intellectual, or biological disorders.

In general, the B.S.S. is based on answering four questions, "Who will be served with what kind of program, where and when." In addition, the B.S.S. attempts to examine the actual performance of the system by ensuring the acceptability of the programs in responding adequately to the goals of the consumer, provider and society; the accessibility of programs and the ability of the system to work co-operatively together. Finally, the Balanced Service System attempts to review the adequacy of the performance of the system through both effectiveness and efficiency review procedures.

2. The California Model[1]

The California Model is based on the philosophy that mental health services, including preventive services be provided in a manner culturally, linguistically, and age appropriate and specific to the nature of the community and the needs of the clients. These services are to be provided in the most humane manner, as close to a normal home environment as possible, and where possible in a community based setting, without sacrificing client safety and care.

The model defines a comprehensive, balanced mental health system as one including levels of care which are not singularly available to clients who require specific treatment, but are linked to one another in a network to provide the most appropriate level or type of service for each client. A client would move through these services as determined by diagnosis and assessment, however, some clients may remain indefinitely at a certain level of care according to individual needs. Linkage between the elements of the system is essential to assuring appropriate service delivery.

Services would be culturally, linguistically and age relevant in a continuum from acute intensive treatment through various non-hospital residential programs to out-patient and community support. The elements would include psychotherapy, medications, other out-patient services, case management and rehabilitation. There would be an emphasis on the priorities of appropriate levels of medication, on the practical skills and rehabilitation necessary to attain independent function, the

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(1) This review paraphrases sections from: A Model for California Community Mental Health Programs, Phase II, Assembly Permanent Subcommittee on Mental Health and Developmental Disabilities, May 1981.

importance of normal residential settings, the assumption of ability rather than disability, and positive expectations of client performance. The system would include smaller facilities, client involvement in decision-making, immersion of the client in the community in normative settings.

The California Model recognizes there is a need for preventive services and acute intervention; however, the needs of the chronically mentally disabled have been given prime consideration in the development of the Model. The other distinctive feature of the California Model is the development of a population based standard, expressed in terms of minimum level of service per 100,000, for ensuring access to the following categories of mental health services.

CALIFORNIA MODEL

Service Function	Standard Service Level Per 100,000 Population
1. Twenty-Four Hour Acute, Intensive Care	15 beds
2. Short-Term Crisis Residential Care	10 beds
3. Twenty-Four Hour Transitional Residential Care	20 beds
4. Long-term Rehabilitative Care	40 beds
5. Out-of-Home Placement	
a) Supervised Out-of-Home Placement	60 beds
b) Semi-Independent Living	15 beds
6. Emergency Services, Crisis Intervention, Screening, Evaluation and Disposition	- 24-Hour Emergency Evaluation Treatment and Holding Services (for approx. 1,000 persons annually). - 1 Crisis Intervention Program (7 da/wk, late afternoon-evening shift, 2 FTE* staff)
7. Acute Day Treatment	- One acute Day Treatment program of 9 staff to deliver 10,400 units of service
8. Outpatient Services	- One Outpatient Clinic 20 staff to deliver 16,250 units of service
9. Case Management	- 8.6 FTE* professional staff Plus support staff and tracking system
10. Community Support Services	13 FTE staff
a) Day Rehabilitation	
b) Socialization	
c) Services to Semi-Independent Living Programs	
d) Respite Care	to be developed
11. Community Services (Consultation, Education, Information, Community Organization and Outreach)	6 FTE staff
12. Mental Health Advocacy	.5 to 1.0 FTE staff
13. Services to the Justice System - Adult & Juvenile	

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* FTE - Full-time equivalent personnel

3. The Denver Model[1]

Within the Denver Model, six smaller, community based therapeutic environments, crisis intervention, home treatment, social systems intervention and rapid tranquilization comprise the essential components of the total community care system. The system operates within a framework of citizen participation and community control, the elimination of formal staff offices and a focus on working in the real-life setting of the client and his family.

This system includes the use of private homes to be used as community residential treatment services; intensive observation apartments to be used for instituting rapid tranquilization procedures and for brief controlled supervision following which clients are transferred to one of the other homes in the system; home day care operating out of one of the other homes in the system; home day care operating out of one of the family sponsors which emphasizes cooking, homemaking and social activities; and back-up hospital beds in a psychiatric hospital to be used when significant side effects to medication occur, when important medical problems need to be evaluated and when behaviour occurs which cannot be controlled adequately in the inpatient alternative system.

In addition, crisis intervention and social system intervention are a central part of treatment. Visits by the client's family members are encouraged and family members may participate in constant observation procedures. Family problems pertinent to both the symptoms of the client and the referral for treatment are

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(1) Much of this review paraphrases, Paul R. Polak and Michael W. Kirby, "A Model to Replace Psychiatric Hospitals" The Journal of Nervous and Mental Disease, Vol. 162, No. 1, 1978.

focussed on intensively both during the client's stay and following discharge from a home.

4. The British Columbia Model[1]

The British Columbia Model attempts to discuss mental health services from the standpoint of the type of severity of the illnesses of the people who approach and use mental health services. Four categories or classifications are utilized: 1. the disabled, 2. the diseased, 3. the distressed and 4. the dissatisfied. This system of classification sets off the disabled from the non-disabled in mutually exclusive categories.

The Disabled

The disabled mental patient is one whose illness does not yield to short term treatment and who has difficulties in performing in the roles expected of his age group. Such a patient has an impaired capacity for work, is unable to seek out leisure time activities, has difficulty sustaining stable relationships with others, and may be unable to take care of his own personal needs. Such patients are very vulnerable to stress and, in spite of treatment with psychotropic drugs, may exhibit disturbing symptoms and behaviours. Many of the mentally ill disabled must be sought out for treatment as they lack the ability to seek help or to sustain contact with sources of health.

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(1) Much of this review paraphrases J. Cumming, Report of the Mental Health Planning Survey, Victoria, May 1979

The majority of the disabled are suffering from chronic schizophrenia or chronic brain syndrome, but there are a few disabled depressed people who do not show the normal competence between acute episodes characteristic of this disease. It is clear that this group includes substantial proportions of middle-aged and other people with perhaps fewer in the younger years.

In terms of service requirements to meet the needs of the disabled population, the British Columbia model indicates that care must be diffuse and constant rather than specific and intermittent and should take into account that the disabled individual has recognizable strengths that can probably be enhanced and may possess a diversity of interests and competences whose encouragement is part of the rehabilitation process. Of particular importance is patient "case management" and an integrated system of support offered by those providing "mainstream" services such as public health, medical assistance, social services, income maintenance, transportation, employment, housing, vocational rehabilitation job finding and recreation.

The Diseased

The term disease refers here to acute mental illness. It includes 1. acute decompensation of the disabled, 2. acute brain syndromes, either on a toxic or metabolic basis (including the acute confusional states seen among the elderly), 3. acute phases of recurrent illnesses such as the unipolar and bipolar depressions, and 4. certain neuroses and personality disorders in their most malignant phases, especially if they must be treated in a controlled environment. The diseased are treated in day hospitals, general hospitals, psychiatric units. Privately practising psychiatrists and general practitioners also treat these patients.

For the chronic patient in a stage of acute decompensation, the B.C. Model proposes the same structure of treatment as that for the disabled. For those individuals suffering from an acute psychotic episode, it is suggested that private psychiatrists be utilized for they have easy access to services, such as hospital beds, needed for the resolution of acute illness. For the acute confusional states of the elderly, the preferred treatment is in an acute psychogeriatric unit with appropriate follow-up.

The third category of "disease", acute phases of recurrent illnesses, includes unipolar and bipolar depressions from which patients can be expected to make relatively quick recoveries, but which carry a high risk of recurrence. Services and treatments for this group include education of the patient to recognize the onset of symptoms, monitoring changes in symptoms, long-term use of medication, admissions to psychiatric in-patient units of general hospitals. This Model recognizes that many acutely ill patients can be treated in day hospitals and a few can be cared for on an outpatient basis. All, however, require access to follow-up care through private psychiatrists, general practitioners, mental health centres or community care teams.

The final category of "diseased" is those suffering malignant forms of neurosis and personality disorders.

Although most patients suffering from neurosis and personality disorders are classified as distressed in this categorical system, there is no clear demarcation between disease and distress as there is between disease and disability. If the patient's condition presents a danger to himself or to others and therefore must be treated in a controlled environment, it should be classified as a disease until it is stabilized. Examples of this borderline category are anorexia nervosa, severe neuroses resulting in suicidal tendencies, and certain acting-out behaviour disorders.

Such patients can usually be stabilized through brief periods in psychiatric units and then transferred to day hospitals or outpatient care. Unlike patients with episodic psychoses, however, most of these require relatively long-term outpatient treatment.

The Distressed

This category includes all those whose mental or emotional difficulties are causing them to experience psychic discomfort, anguish or distress.

While there is no sharp border between the distressed and the diseased, most of the distressed can be treated under conditions of normal social control except when a restricted setting, such as an inpatient unit, is needed to protect the patient from the malignant effect of his environment.

It is convenient to consider three types of distressed people:

1. those who have experienced some event about which stress is normally considered to be appropriate. Loss of a relationship with an important person through death, divorce or other separation induces distress, and if the usual methods of dealing with loss are not available, it can lead to a disease such as depression. Similarly, any loss or failure at work or in another important life area may cause distress because of the need to readjust the self-concept or identity. Most people with adequate interpersonal support

systems can work through distress to a new equilibria. If, however, support is absent or unavailable for any reason, or if the distressed person retreats from using available supports, help may have to come from a mental health professional.

2. those whose psychological makeup is such that they react excessively to events or other stimuli not usually judged to be distressing. When the noxious stimulus is varied or imprecise the reactions are generally termed anxiety neuroses. When the stimulus is concrete and specific the reaction is a "phobia". Either of these types of stimuli can produce reactions varying from mild discomfort to paralyzing distress. Furthermore, some stimuli are easier to avoid than others, and the social consequence of this avoidance varies. To a person who does not fly, for example, a phobia about airplanes is inconsequential, while to a flight attendant it is all-important.

3. those whose distress arises from a distortion of interpersonal relationships. A mild form of this disorder is shown by a patient, anxious to be liked, who consistently acts in ways that make it difficult to like him. A more serious form of the disorder is shown by the patient who repeatedly destroys valuable relationships because of his inability to meet the normative expectations inherent in these relationships. In all such cases, non-functional patterns produce the very result that they were intended to avoid.

As well as overt psychic distress these distressed patients can exhibit a host of physiological responses such as headache, muscle spasm, gastric distress and many more.

The methods of treating these three types of distressed people are as varied as the problems themselves. They include:

a) supporting the patient through the transition period following loss, and assisting him to use it for any growth potential it may have.

b) removing the patient from noxious stimuli or events, or ameliorating the consequences of the stimuli through desensitizing techniques, relaxation therapies, or anxiolytic drugs.

c) providing opportunities for examining non-functional patterns and learning more successful ones.

With the exception of the use of tranquilizers, these interventions are all interpersonal, and the therapist can act in the role of counsellor, listener or teacher. Almost everyone is a candidate for help from family, friends, clergymen, general physicians and so on without resorting to defined mental health professionals. It should be noted, however, that for many years the mental health movement has urged the use of mental health professionals for all kinds of psychic distress, and it may be for this reason that such patients consume so large a share of outpatient treatment time.

The Dissatisfied

This group of people can be viewed as the consequence of a modern ideology that puts the welfare of the individual ahead of that of the group. When people are expected to attend first to their own self-fulfillment or actualization and only secondly to their obligations to people and institutions, any failure in the expected feelings of fulfillment may come to be blamed on those obligations, whether they be marriage or work. In other words, this younger segment of the population relates well to itself but poorly to society and its institutions.

People complaining of these dissatisfactions should be distinguished clearly from those suffering distress or disease, as they may present similar problems, for example marriage breakdown. They do not, however, require clinical intervention, but perhaps some assistance in commiting themselves to their role obligations. Exactly who should take responsibility for dissatisfactions is not clear, but it should probably not be at present a publicly supported health system.

APPENDIX C

PERSONS AND GROUPS CONSULTED

SERVICE PROVIDERS AND PLANNING BODIES

Addiction Research Foundation, Toronto
Belleville General Hospital
Children's Psychiatric Research Institute, London, Ontario
Clarke Institute of Psychiatry, Toronto
C.M. Hincks Treatment Centre, Toronto
Cornwall General Hospital
District Health Councils
Douglas Hospital, Montreal
Etobicoke Mental Health Services Agency, Toronto
Extendicare Ltd.
Greater Vancouver Mental Health Services, Vancouver, B.C.
Homewood Sanitarium, Guelph
Hospital for Sick Children, Toronto
Kingston General Hospital
Meadowcrest Home, London, Ontario
Medical Officers of Health
Metropolitan Toronto Forensic Service
Nellie's Shelter for Abused Women, Toronto
North York Inter-Agency Council, Toronto
Oshawa General Hospital
Ottawa-Carleton Regional Health Unit
Provincial Psychiatric Hospitals
Royal Ottawa Hospital
Sudbury Algoma Hospital
Sunnybrook Medical Centre, Toronto
West End Creche Child and Family Clinic, Toronto

ASSOCIATIONS/ORGANIZATIONS/PATIENT ADVOCACY GROUPS

Association of Municipalities of Ontario
Canadian Association of Psychoanalytic Psychotherapists for Children
Canadian Mental Health Association/Ontario Division
Coalition on Psychiatric Services
College of Physicians and Surgeons
On Our Own
Ontario Association for the Mentally Retarded
Ontario Association for Children's Mental Health Centres
Ontario Association of Children's Psychiatric Centres
Ontario Association of Family Service Agencies
Ontario Association of General Hospital Psychiatric Services
Ontario Friends of Schizophrenics
Ontario Hospital Association
Ontario Medical Association
Ontario Nursing Home Association
Ontario Psychiatric Association
Ontario Psychological Association
Ontario Public Service Employees Union
Patients' Rights Association
Registered Nurse's Association of Ontario
Supportive Housing Coalition

GOVERNMENT

Health and Welfare Canada
Inter-Ministerial Placement Action Committee (IMPAC)
Interministry Committee on Housing and Supportive Services for Discharged Psychiatric Patients
Ministry of Colleges and Universities
Ministry of Community and Social Services
Ministry of Correctional Services
Ministry of Education
Ministry of Government Services
Ministry of Municipal Affairs and Housing
Ministry of Northern Affairs
Municipality of Metropolitan Toronto
Provincial Secretariat for Social Development
Provincial Mental Health Directors

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Dr. Barrie Humphrey, McMaster University, Hamilton
Dr. Alex Richman, Dalhousie University, Halifax
Touche Ross & Partners, Toronto

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APPENDIX D

WRITTEN RESPONSES TO INTERIM REPORT

SERVICE PROVIDERS AND PLANNING BODIES

Central Region Directors of Public Health Nursing
Central Toronto Youth Services
Community Occupational Therapy Associates
Community Resources Consultants of Toronto
Etobicoke Mental Health Services Agency
Ottawa-Carleton District Health Council, Mental Health Committee

ASSOCIATIONS/ORGANIZATIONS/PATIENT ADVOCACY GROUPS

Association of General Hospital Psychiatric Services
Association of Municipalities of Ontario
Canadian Association of Psychoanalytic Psychotherapists for Children
Canadian Mental Health Association/Elgin
Canadian Mental Health Association/Niagara Falls
Canadian Mental Health Association/Ontario Divison
Canadian Mental Health Association/Ottawa-Carleton Branch
(Community Action Committee)
Canadian Mental Health Association/Waterloo Region
Coalition on Psychiatric Services
College of Family Physicians of Canada (Ontario Chapter)
Ontario Association of Children's Mental Health Centres
Ontario Association of Professional Social Workers
Ontario Municipal Social Services Association
Ontario Public Service Employees Union (Local 431, Kingston Psychiatric Hospital)
Ontario Public Service Employees Union (Local 439, Brockville Psychiatric Hospital)
Ontario Public Service Employees Union (Ministry of Health Negotiating Team)
Psychiatric Nursing Interest Group of the Registered Nurses' Association of Ontario

HOSPITALS

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Doctor Joseph O. Ruddy General Hospital
Homewood Sanitarium
Mississauga Hospital
Oshawa General Hospital
Royal Ottawa Hospital
Sudbury Algoma Hospital

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